

The Madras Clinical Journal

Vol. XXIX

June 1963

No. 12

CONTENTS

	PAGE
1. Abdominal Tumours in Gynaecological and Obstetrical Practice — Vishnu Sarma	291
2. Preventive Pediatrics — V. Balagopala Raju	307
3. Abstracts and Excerpts	317
4. Association Notes	324
5. X-Ray Machinery for Sale	302
6. Dr. C. S. Thakkar Oration Award	323
7. State President's Letters	337
8. Madras State Branch — Amendment to Rule 20	339
9. Madras Medical Council — Disciplinary Cases	339

GAJJARTONE

(WITH OR WITHOUT CREOSOTE AND GUAIACOL)

A pleasantly flavoured VITAMIN MINERAL COMPOUND introduced to the Indian Market in the year 1956 after extensive chemical and clinical tests.

Each 30 ml. contains:

Spleen substances derived from 0.26 G. of raw Spleen.
Proteolysed Liver Extract derived from 0.53 G. of raw Liver.
Proteolysed Stomach Extract derived from 0.17 G. of raw Stomach.

Pancreatin N. F.	18.0 mg	Iron Peptonate	64.0 mg
Manganese Citrate	64.0 mg	Creosote from woodl B. P.	0.14 ml.
Guaiaicol N. F.	0.005 ml	Sodium Hypophosphite B.P.C.	35.0 mg.
Potassium Phosphate N. F.	42.0 mg	Malt Extract B. P.	1.5 ml.
Thiamine Mononitrate U S P	10.0 mg	Riboflavine B. P.	1.0 mg.
Niacinamide B. P.	20.0 mg		

Syrup flavoured with Extract of Wild Cherry and Liq Tolu. Q. S
Alcohol (absolute) 11% v/v approx.

Manufactured & Marketed by:

PROF. GAJJAR'S STANDARD CHEMICAL WORKS LTD.

(Estd. 1902)

2, MASRANI LANE, KURLA, BOMBAY-70

DIAMOX*

NONMERCURIAL DIURETIC

ACETAZOLAMIDE

IN GLAUCOMA

* TRADEMARK

AN EVER-WIDENING CIRCLE OF THERAPEUTIC INFLUENCE

diagnostic

preoperative

postoperative

Well-tolerated, virtually nontoxic, easily administered, carbonic anhydrase inhibitor, DIAMOX has proved highly effective—significantly reducing intraocular pressure in various types of glaucoma: acute congestive glaucomatous crisis, simple glaucoma not responsive to miotics, and certain secondary glaucomas.

Suggested dosage of DIAMOX for most ophthalmological conditions is 5 mg. per kg. every six hours day and night.

PACKAGE: DIAMOX Acetazolamide Tablets of 250 mg. (grooved)—Bottles of 10 and 50



**LEDERLE LABORATORIES DIVISION
CYANAMID INDIA LIMITED
P.O.B. 1994**

BOMBAY-1



The Madras Clinical Journal

JOURNAL OF THE MADRAS STATE BRANCH OF THE INDIAN MEDICAL ASSOCIATION
(WITH WHICH IS INCORPORATED THE "MISCELLANY")

Vol. XXIX

June 1963

No. 12

ABDOMINAL TUMOURS IN GYNAECOLOGICAL AND OBSTETRICAL PRACTICE*

VISHNU SARMA, M. A. (Cantab), M. D. (Cantab), B. Chir., M. B. C. S. (Eng.),
L. R. C. P. (Lond.), D. G. O. (Madras).

Fellow, The Royal Society of Medicine, London.

Tutor in Obstetrics and Gynaecology, Stanley Medical College,
(The Government R. S. R. M. Lying-in Hospital), Madras.

"Progress in Obstetrics and Gynaecology is denoted among other things by greater accuracy of diagnosis. When mere opening of the peritoneal cavity, more often than not, meant death from general peritonitis, much thought and time was spent on pre-operative diagnosis. When it was demonstrated beyond doubt that by proper precautions the peritoneal cavity could be invaded with impunity, pre-operative diagnosis of gynaecological pelvic and abdominal conditions became less accurate and often were not made at all. It has been so easy to excuse our intellectual laziness in diagnosis by saying that it makes no difference since the correct diagnosis will be made after abdomen is opened. To look in and see may be dangerous even fatal and is crude surgery especially with modern diagnostic aid".

— Peterson (1921)

There is no doubt that tumefaction of the abdomen is one of those problems which constantly obtrudes itself into gynaecological and obstetrical practice. The female patient turns up with an abdominal swelling and one has to determine what it is.

Palpable abdominal masses are mentioned in the earliest known medical writings. The Papyrus Ebers (1500 B. C.) described methods of

abdominal palpation and discussed differential diagnosis of abdominal masses. Morgagni (1769) correlated the clinical findings of abdominal masses with the necropsy findings in the latter half of the eighteenth century. He described mesenteric tumours in great detail. He pointed out the differential features of abdominal aneurysms and abdominal tumours. He discussed the differential diagnosis of ovarian cysts and ascites.

* This was the subject of an address at the 33rd Inaugural meeting of the Tiruchirappalli District Medical Association on 9th December 1961.

Bright (1860) described many of the features in the physical examination of abdominal masses. "The sources to which we turn for evidence respecting the existence and nature of abdominal tumours are: the form and appearance presented to the eye, the form still further discovered with touch, the resistance ascertained by pressure, the sounds elicited by percussion; and in a few instances, the sounds perceptible to the ear, either alone or by the aid of the stethoscope; and besides these local conditions we look to the general condition of the system".

Accurate history taking and careful examination is essential to hope to make a correct diagnosis of abdominal tumours. Crohn (1927) emphasized, "Abdominal diagnosis for accurate and exact differentiation of masses is an extremely difficult task. Even in the hands of the most experienced clinicians, mistakes in this connection will still happen".

One should as far as possible develop a systematic approach to abdominal examination. Any examination should be preceded by an accurate history. I have adopted a particular method which I will briefly outline (Sarma 1961).

Symptoms and signs in the general examination of a patient (Obstetrics & Gynaecology):

Examination of the Abdomen:

Inspection: General appearance, contour, normal fullness, swollen, protruberant, sunken, retracted, general enlargement, bulging or distension (fat, fluid, flatus, faeces, foetus or new growths), distension in antero-posterior and transverse diameter, local enlargement (specify zone in which it is present). Does swelling

move with respiration? Pulsation in the epigastric region—present/absent. Movement of the abdominal wall—present/absent; normal/abnormal. Peristaltic movements present/absent (specify direction). Foetal movements—present/absent. Abnormal pigmentation or discolouration—present/absent. Surface of the abdomen—smooth/glossy/striae/abnormal surface vein pattern/caput medusae. Umbilicus depressed, on level with surface/everted/protruberant/oozing, discharge, discolouration, swelling of navel/other. Hernial orifices—normal/abnormal.

Palpation: Tension of the abdominal walls/resistance/general and localized rigidity/hypaesthesia/absence of abdominal and skin reflexes, local or general tenderness.

Does viscus harden under examining hand?

Abdominal swelling—present/absent. If present, is it general or local?

Is the tumour on the abdominal wall or within the abdomen?

Is it abdominal or abdomino-pelvic?

Is it tender?

Does it move with respiration?

Does it appear to be related to any abdominal organ?

If it moves, in which direction does it move?

Size: small/medium/large/enormous. Situation and position (Indicate on figure) (Figure 1).

Measurement (in cms/ins): Circumference of the abdomen (in cms/ins):

Shape: spherical/ovoid/other.

Attachment.

Contour: smooth/lobulated/irregular/other.

Consistency : hard/solid/cystic/fluctuant/other

Other features : (specify)

Hepatomegaly, splenomegaly, enlargement of the kidney, other.

Percussion : Resonant/tympanitic/shifting dullness/fluid thrill/other.

Auscultation : Borborygmi—present/absent silent/murmurs/foetal heart sounds/other.

General abdominal swelling/local abdominal swelling.

General abdominal swelling : Pregnancy/obesity ascites/acute or chronic intestinal obstruction/retention of urine/ gastropnoia/enteroptosis/large ovarian cyst/tuberculous peritonitis/splenomegaly / psuedocyesis / dilated colon/tympanitis/other.

By following a systematic method of examination, it should be possible to answer the following questions :

1. What is the mass ?
2. Is it an enlarged organ or an independent growth ?
3. How can the clinical history and the presence of the mass be correlated in a single clinical picture ?
4. What further examination and laboratory tests might help in diagnosis ?
5. How does the presence of the mass affect the choice of treatment and ultimate prognosis for the patient ?

The number of diagnostic possibilities of a swelling in the female abdomen is legion. It is not possible to do anything more than to consider some of the more common tumours which one might encounter in practice.

Abdominal tumours in gynaecological and obstetrical practice :

Normal intrauterine pregnancy

Intrauterine but dead pregnancy

Extrauterine pregnancy

Pregnancy in a malformed uterus

Hydatidiform mole

Chorioncarcinoma

Haematocolpos

Fibromyomata of the body and the cervix of the uterus

Cancer of the corpus of the uterus

Pyometra secondary to cervix cancer

Uterine sarcoma mixed mesodermal tumour

Adenomyosis of the uterus

Abdominal lymph node deposits from cervix cancer

Hydrosalpinx

Pelvic inflammatory masses

Endometrioma of the ovary

Ovarian tumours

Simple cysts of the ovary

Multilocular psuedomucinous cyst-adenoma

Adenocarcinoma

Dermoid-Teratoma

Granulosa cell tumour

Arrhenoblastoma

Dysgerminoma

Fibroma

Krukenburg

Broad ligament tumours

Extragenital tumefactions

Carcinoma of the stomach

Ileus or intestinal obstruction

Growths and other lesions of the colon

Appendix abscess

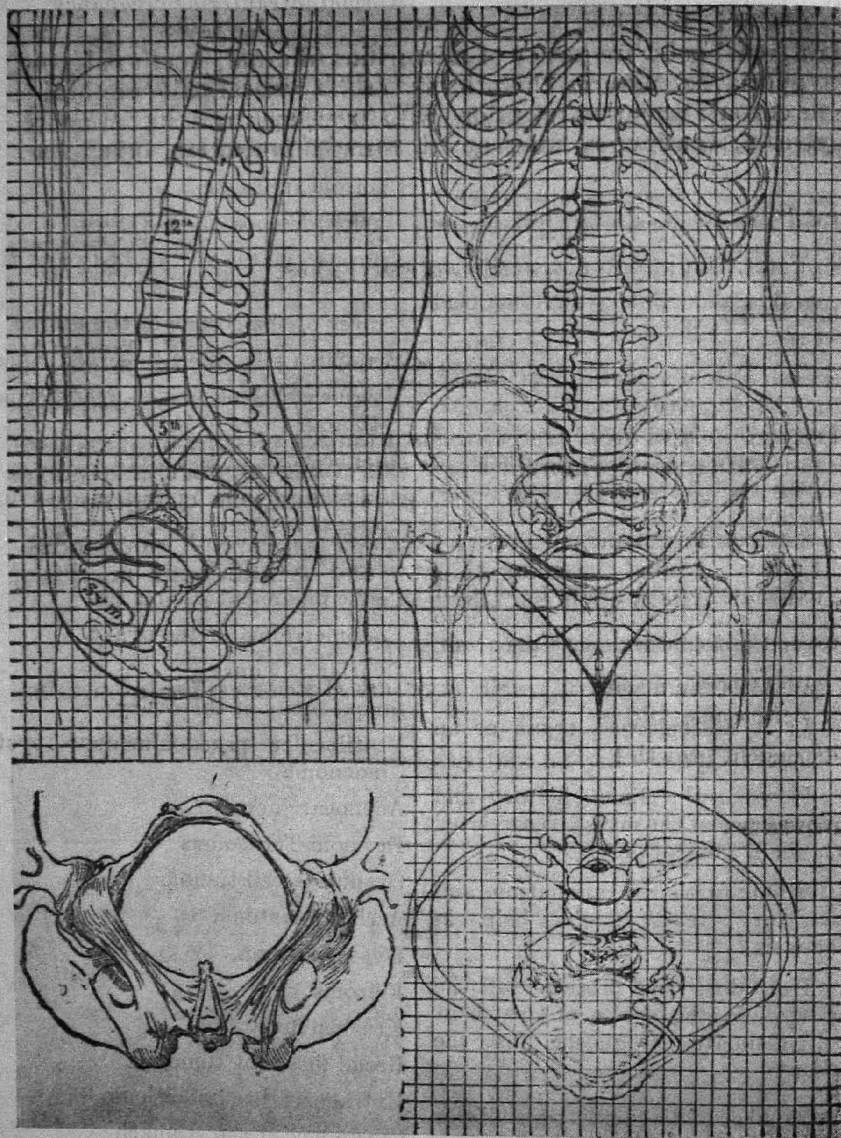
SYMPTOMS AND SIGNS IN THE GENERAL EXAMINATION OF A PATIENT
(OBSTETRICS AND GYNAECOLOGY) — (Contd.)

FIG. 1

Region	Pain	Tenderness	Swelling	Other
Epigastric ...				
Right hypochondriac ...				
Left hypochondriac ...				
Umbilical ...				
Right lumbar ...				
Left lumbar ...				
Hypogastric ...				
Right iliac ...				
Left iliac ...				
Right inguinal ...				
Left inguinal ...				

The chart was devised by Howard Kelly to depict abdominal tumefaction in three dimensions. It is surprising why this chart seems to have gone out of current use for it is ingenious and has great utility; it appears in Kelly's *Gynecology* (1928) published by D. Appleton and Co., New York.

Loaded rectum or faecal scybalous mass in the colon

Tumours of the liver

Pancreatic cysts

Obesity

Desmoids

Rectus sheath haematoma

Abdominal hernia

Peritoneal cyst

Peritoneal collections of fluid, tuberculous peritonitis

Omental cysts

Mesenteric cysts

Hydatid cysts of the pelvis

Retroperitoneal tumours

Renal lesions; Hydronephrosis; hypernephromas; ectopic kidney; full bladder—bladder growths

Adrenal cysts and other lesions

Bone tumours

Aneurysms

Splenic swellings and lymphadenopathy

Intrauterine Pregnancy (Figure 2):

"Any woman in her menstrual prime (that is from 15-50 years of age) whose periods in any way depart from their normal behaviour, must be considered to be pregnant inside or outside the womb until disproved," emphasized Howkins (1959). It is particularly important that in any woman who has an abdominal tumour, pregnancy should be considered as a possibility and every effort made to exclude this condition. It should be remembered that a female patient may fail to give a history of suppression of menstrual periods and may even withhold vital information from her physician. When such a patient falls into the unsuspecting hands of a

general surgeon, the possibility of pregnancy may be the last thought to pass his mind.

A 19 year old unmarried girl was admitted to the surgical side of a hospital which treats general diseases. She gave a history of all sorts of funny complaints and along with it 2 years of amenorrhoea. She had an abdominal tumour reaching to the level of the umbilicus. Her bizaare complaints put the surgeon right off the track and she was referred for an E. N. T. opinion and also a plain x-ray of the abdomen for evidence of calcification. The appearance of a dead foetus on the plain x-ray came as something of a surprise and the surgeon wanted to know how it could possibly have happened considering she was unmarried and also had amenorrhoea for 2 years. The patient confided in the gynaecologist to a clandestine affair with her lover.

The point of this story is that you should consider every girl or lady with an abdominal tumour to be pregnant until it is disproved, whether she be married or not, a virgin or a widow. If this is not borne in mind, you might get caught out rather badly.

A 29 year old patient complained of abdominal pain of a month's duration which was more severe recently. Further she misled us with a history of two months' amenorrhoea. She stated that she had had an abdominal operation previously but did not know what had been done. She bore a right-sided paramedian scar on her lower abdomen. She was examined by several gynaecologists and all were of the opinion that there was a mass close to the uterus pushing the body of the uterus to the left side. In due course a laparotomy was done and a normal pregnant uterus about 20

weeks in size was discovered. There is nothing surprising about this, for for the vagaries of a pregnant uterus, not to mention the vagaries of the female who harbours this structure, are most unpredictable. Some portions of the uterus may feel soft and others hard and the uterus may be laterally bent or inclined forwards that one may easily be misled at times by physical examination. Add to that the wily female determined to mislead you with an erroneous history and the confusion is complete.

Pregnancy in a malformed uterus:

Another factor that sometimes causes confusion is abnormalities in the formation of the genital tract. You may recollect how the two Mullerian ducts fuse together to form a single uterus, but there are various imperfections in fusion. Sometimes there is no fusion at all and there are two separate uterine horns. If the uterus is made up of two partially fused horns and pregnancy enlarges one horn, it is quite easy to diagnose an ovarian tumour or other adnexal tumour complicating pregnancy. This is particularly so when a rudimentary horn is present and this becomes the seat of pregnancy.

A 30 year old woman who had given birth to a premature child soon after marriage more than 15 years back reported complaining of abdominal discomfort and of noticing an abdominal swelling. A year back she had amenorrhoea for 6 months and abdominal pain. She reported to a hospital where she was examined and an x-ray was taken and she was told she was pregnant; but she became better soon after that. After she returned home her periods began coming once a month regularly. At the time of examination she had 2 months amenorrhoea. A diagnosis

of an adnexal tumour was made and further detailed investigations enabled one to suspect very strongly that the condition might be pregnancy in a rudimentary horn of the uterus. This was verified at laparotomy and the abnormal horn with its adnexa was removed. What was not apparent until later was that she carried an early pregnancy in the normal horn. This surprising discovery was made after she aborted from the normal horn. This is an exceptionally rare and most remarkable case, but it does emphasize that accuracy in diagnosis is facilitated by modern diagnostic methods.

Hydatidiform mole: Another interesting disease, more common in our country than in the West, is hydatidiform mole. This disease represents a genuine although abnormal pregnancy and may produce in the maternal organism all the signs and symptoms generally attributed to pregnancy. The uterus may be softer than normal and enlarges with unusual rapidity. Hyperemesis may be severe, or toxæmia may make an unusually early appearance. Variations in the signs and symptoms of pregnancy, particularly accompanied by bleeding should lead one to suspect hydatidiform mole. The chance of any pregnancy being molar in character increases in older age groups, so that in women over the age of 40 any pregnancy accompanied by abnormal symptoms may be regarded with suspicion (Douglas 1957).

A lady who gave her age as 50, mother of 10 children all of whom were alive and well, complained of profuse vaginal bleeding after 2 months of amenorrhoea. It appears she had aborted once in her lifetime, 3 years previously. She had been given some form of therapy for pain

in her abdomen 2 years previously. The course lasted for 4 weeks. At the time of admission her abdominal tumour, thought to be uterine in origin, was about 18-20 weeks. A plain x-ray of the abdomen showed absence of foetal parts. Vesicular mole was suspected and the diagnosis was confirmed by amniography. In view of her age and the nature of her lesion, the enlarged uterus containing the abnormal pregnancy was removed by total hysterectomy and both adnexae were also removed.

Wharton (1961) recently had a case of pregnancy in a fifty-five year old lady which turned out to be a molar one and she was treated successfully by hysterectomy with excellent results. It appears there were only two pregnancies at the John Hopkins in women over fifty and both ended in hydatids. (Personal communication, Wharton 1961).

Trophoblastic growths arise from foetal elements, from the chorion. The benign growths are the hydatidiform mole, the intermediate ones are locally destructive (destructive mole or invasive mole) and finally we have the lethal chorion-carcinoma. In our part of the world, these growths are far more common than they are in England or in the States. When you come across patients who develop evidence of toxæmia early in pregnancy, hypertension, albuminuria, oedema (especially vulval), think of vesicular mole. When a patient has postabortal bleeding or continuous bleeding following a molar pregnancy, presume you are dealing with the dreaded chorion epithelioma until it is disproved by the most meticulous investigation.

Remember that every patient who has haemoptysis has not got pulmonary tuberculosis. Have a look at

the suburethral region for bluish deposits and more than that get a correct history and evaluate it. If you can't, you can do service by sending her speedily for a gynaecological consultation. These growths are dangerous to temporize.

A female patient 35 years old was admitted to a hospital for general diseases for investigation of fever of a week's duration and diarrhoea on the day of admission. You will be surprised to know in what detail she had been investigated, but nothing much was made out. She was kept in the hospital for two weeks and given a course of treatment for diarrhoea with bismuth, diaphoretic mixture and sulphadiazine. At the end of this time the patient told her attendant that she had a vaginal discharge and a few days later that she had something bluish in the region of the vulva. She was quite ill. It became evident that female genital tract disease should be enquired into and she was sent for gynaecological opinion. Note the difference in the attitude between the physician and the gynaecologist. If the general physician viewed the patient mainly as "heart, lungs, liver and spleen" and the genitalia as secret parts which should be dealt with great discretion, if at all, the patient was now viewed as "an ambulant female genital tract with heart and lungs, the function of which was to maintain its nutrition". The multiparous patient now gave a history of an offensive vaginal discharge and episodes of profuse uterine bleeding of four months' duration. On further questioning, she gave a history of a molar pregnancy having been terminated by abdominal hysterotomy a year previously and what is more she bore a fine scar in the hypogastric region which had not

been noticed. She had a midline hypogastric tumour almost 20 weeks in size and a vaginal examination revealed an open cervix through which the finger could be readily inserted to feel a necrotic vascular growth. A frog test on the urine was positive. Soon after admission, she had nausea and attacks of haemoptysis. A chest x-ray revealed multiple metastatic deposits in both lung fields. The patient's condition deteriorated in spite of treatment and her relatives took her away to die at home. Here is a case of chorion-carcinoma which could have readily been diagnosed on admission by any doctor with a little care and thoroughness; in this particular case it may have made no difference to the outcome, for there is little hope for advanced cases, but then the diagnosis was missed because of neglect in history taking and lack of thoroughness in the physical examination.

Abdominal tumour due to haematocolpos: A young girl may be brought to you as not having attained puberty when she should have done. In such a case, physical examination is most important, for there may be structural abnormalities such as an imperforate hymen (obstructing membrane) or vaginal agencies associated with a lack of development of the uterus. Many of the unfortunate patients with this complaint, although they do not have menses, have their secondary sexual characters well developed and are quite feminine. The general practitioner who treats these patients with hormones without making a diagnosis does not help them at all.

Imperforate hymen with haematocolpos: Over 300 years ago, Ambroise Pare described a case of imperforate hymen with haematocolpos which, because of amenorrhoea, abdominal

pain and swelling, was mistaken for pregnancy. Amenorrhoea, pelvic pain, abdominal swelling and urinary symptoms should lead to imperforate hymen being suspected. (Figure 3.).

14 years old Lakshmi's parents were worried because their daughter had not attained puberty. They took her to see a doctor in a local hospital. Lakshmi had an abdominal swelling and it was a little tender and the doctor advised a course of penicillin therapy for ten days. Her abdominal pain became slightly better and the doctor thought that the swelling was much smaller and reassured her and sent her away. A fortnight later she had difficulty in passing urine. So the parents thought there must be something really wrong and took her to the big city hospital where they treat general diseases. Her abdominal swelling was recognized and she was submitted to a great number of investigations, some of them of quite a specialized nature and not without risk. The haemoglobin was 70 per cent; the white cell count was 7200; the urine contained no albumin or sugar; the centrifuge deposit was normal; there were no ova or cysts in the motion; there were no acid fast bacilli in the sputum. A chest x-ray showed the lungs to be healthy. A blood urea and a special renal function tests gave normal readings. Urographic studies and barium meal series showed no abnormality. Fortunately, Lakshmi's parents did not have to pay for all these expensive tests. After a course of antibiotics, it was decided that the only way of finding out what the tumour was would be to open her abdomen. Fortunately, the surgeon recognized what he found and refrained from removing all the internal genitalia. The vagina was grossly distended with a collection of blood and above this a uterus with

its tubes was perched. He released some of bloody fluid and the swelling more or less disappeared. The abdomen was closed. Afterwards the surgeon looked at the external genitalia and found an obstructing membrane to be present. In due course, after the patient convalesced from the operation, she was referred to a gynaecologist. The gynaecologist readily diagnosed the trouble and made a small incision on the obstructing membrane in the vagina, allowed all contents to escape and kept the vagina from closing by regular dilations. This is a very instructive case in that the most elaborate investigations did not help in the diagnosis, when a simple thing like inspecting the external genitalia or doing a rectal examination would have made the diagnosis obvious. The poor girl was subject to a needless abdominal operation, when a simple incision in the vaginal membrane would have cured her. There is one consolation. The operator recognized what was wrong on opening the abdomen. Sometimes the true nature of the condition is not recognized even at operation and the internal genital organs are sacrificed. There are plenty of references to such tragedies in the medical literature.

Teratoma of the ovary: (Figure 4) A young girl aged 13 years who had just begun menstruating a few months previously was admitted to the Gsindhiji Memorial Hospital at Trichy. She had repeated attacks of abdominal pain and at the time of admission she was having a subacute abdomen and a palpable abdominopelvic tumour. The diagnosis was suggestive of an ovarian tumour. In a case such as this an x-ray can be of considerable help. In this case it showed the soft tissue swelling of a tumour with innumerable calcified areas.

diagnosis of ovarian teratoma was made and torsion of the tumour was suspected and this diagnosis was verified at laparotomy next day and its correctness confirmed.

Cancer of the ovary: (Figure 5) Cancer of the ovary is lethal. Indeed it is termed a silent killer. The overall salvage of cancer of the ovary (if you exclude certain special forms) is only about 20 to 25 percent. The text books on gynaecology are also to blame to some extent, because they leave the student with the clinical picture of an advanced ovarian malignancy. Uterine bleeding with consequent anaemia, a foul irritating discharge, fixed bilateral pelvic masses, enlarged hypogastric nodes and cachexia, abdominal swelling often due to associated ascites, omental masses and distant supraclavicular and other metastasis are not helpful signs which make for early diagnosis. Perhaps the only hope of recognizing ovarian cancer at an early enough stage is to perform routine examinations on all women of cancer age. Although this may hardly be practicable, it should be a wise policy to include a pelvic or a rectal examination as part of a routine examination before performing abdominal or other operations on surgical patients and to do as a routine this examination in medical cases with obscure presenting symptoms such as anaemia, vague abdominal pain, dyspepsia, etc.

In his book on malignant diseases of the female genital tract, Way quotes the case of a 52 years old woman who was referred to the hospital on account of postmenopausal bleeding of 3 weeks' duration. On examination, bilateral ovarian carcinomas with a deposit at the lower end of the vagina were found. The condition was quite hopeless and she died two

months afaer laparotomy. The history revealed, however, that two years previously she had been investigated in a London teaching hospital for vague abdominal pain thought to be due to pyelitis, and six months after this she had been investigated in the medical department of a large provincial hospital for indigestion thought to be due to a gastric ulcer. Way remarks, "How many early carcinomas have been nurtured in a sea of bicarbonate of soda and potassium citrate by the practitioners of the world cannot be even guessed, and it is sad but probably true to say that if bicarbonate of soda were reserved for the obvious case and the case with abdominal swelling and pain and vague symptoms was investigated at once, the results would probably be much better".

When I was Dr. Rodney Maingot's house surgeon for a short time, once I remember a case which was wheeled in for radical surgery for gastric cancer. The patient had been elaborately investigated, but one little examination had been left out. Rodney Maingot did a pelvic examination and found secondaries in the Douglas' pouch and he sent the patient back to the ward.

Large ovarian tumours are sometimes mistaken for cases of ascites and I saw one such case recently where there were residual abdominal masses after tapping. (Figure 6). The provisional surgical diagnosis was lymphosarcoma arising in the lymph nodes. Laparotomy showed a large ovarian pseudomucinous cystadenoma, one of the large loculi having been successfully tapped by the physician.

The speaker considered several other lesions listed in the table and demonstrated interesting photographs and x-rays.

REFERENCES

- Adams, F. Dennette (1958) *Physical diagnosis*, The William and Wilkins Co., Baltimore.
- Brower, J. I. (1951) *Textbook of gynecology*, 3rd edition, The William and Wilkins Co., Baltimore.
- Bright, Richard (1860) *Clinical memoirs on abdominal tumours and intumescence*, The New Sydenham Society, London: 326.
- Bryan, C. P. (1930) *Translator, The Papyrus Ebers*, Geoffrey Bles, London: 167.
- Butler, D. B. and Bagen, I. A. (1951) *Abdominal masses*, *Gastroenterology* 19, 1: 1 and 2: 283.
- Copeland, W. E. (1959) *Female genitalia in physical diagnosis. The history and examination of the patient*, edited by Prior, J. A. and Silberstein, J. S., C. V. Mosby Co., St. Louis.
- Crossen, R. J. (1953) *Diseases of women*, 10th edition, The C. V. Mosby Co., St. Louis.
- Das, K. (1961) *Clinical methods in surgery including differential diagnosis*, 6th edition, Calcutta-6.
- Duncan, A. S. (1955) *Physical examination and methods of diagnosis in gynaecology, British Obstetrical and Gynaecological Practice*, edited by Holland, Sir Eardley and Bourne, Aleck (1955) William Heinemann Medical Books Ltd., London.
- Gaines, J. A. (1954) *Ovarian neoplasms*, *Ciba Clinical Symposia*, 6, 4: 107; 6, 5: 189.
- Howkins, J. (1956) *Shaw's text book of gynaecology*, 7th edition, J. and A. Churchill Ltd., London.
- Kelly, Howard, A. (1928) *Gynaecology*, D. Appleton and Co., New York & London.
- Morgagni, J. B. (1760) quoted by Butler and Bagen (1951).
- Neuweiler, W. (1952) *Hand book of gynaecological diagnosis for practitioners and students*, William Heinemann Medical Books Ltd., London.
- Novak, E. and Novak, E. R. (1952) *Gynaecology*, 4th edition, The William Wilkins Co., Baltimore.
- Peterson, R. (1921) *Errors in gynaecological diagnosis due to misplaced organs*, *Amer. J. Obstet. and Gynec.* 1: 170.
- Reich, W. J. and Nechtow, M. J. (1957) *Practical gynaecology*, J. B. Lippincott Co., Philadelphia.
- Rosenthal, A. H. and Block R. E. and Lapin, A. (1958) *The imperforate hymen as a cause of "abdominal tumour"*, *The Amer. J. Surgery* 95, 3: 487.

- Rubin, I. C. (1931) Symptoms in gynaecology, etiology and interpretations with notes on diagnosis, Gynaecological and Obstetric monographs, D. Appleton and Co., New York and London.
- Sarma, Vishnu (1961) Cysts of the mesentery simulating gynaecological lesions, *Indian Practitioner* 14, 10: 901.
- Sarma, Vishnu (1961) Gynaecological and obstetrical aspects of tropical diseases, *Mediscope*, 4, 5: 181.
- Sarma, Vishnu (1961) Obstetrics and gynaecology. A method of maintaining records, *Surgical and Medical News*, 7, 3: 20.
- Sarma, Vishnu (1961) Paediatric gynaecology, *Surgical and Medical News*, 8, 1: 27.
- Sarma, Vishnu (1961) Renal and extrarenal swellings simulating ovarian tumours, *The Medicine and Surgery*, 1, 8/9: 129.
- Sarma, Vishnu (1957) Retroperitoneal tumours and the gynaecologist, *J. Indian Medical Profession*, 3, 2: 1487.
- Sarma, Vishnu (1958) The gastrointestinal tract and related structures in obstetrics and Gynaecology, *Surgical and Medical News*, 5, 2: 5; 5, 3. 29; 5, 4: 16 and 6, 1: 81
- Sarma, Vishnu (1959) The genitourinary tract in obstetrics and gynaecology, *Surgical and Medical News*, 6, 2: 6.
- Sarma, Vishnu (1958) The value of diagnostic radiology in obstetrics and gynaecology. *The Surgical and Medical News*, 4, 3: 37.
- Stromme, W. B. and Stander, H. J. (1956) Retroperitoneal tumours simulating genital tract neoplasms, *Amer. J. Obstet. Gynec.* 52: 456.
- Wharton, L. R. (1947) Gynaecology (With a section on female urology) W. B. Saunders, Co., Philadelphia and London.
- Wharton, L. R. (1961) Personal communication.

X-Ray MACHINERY FOR SALE

The following X-Ray and other instruments belonging to late Dr. P. S. Ramaswamy, National X-Ray Institute, Salem are available for immediate sale:— (1) Victor (I. G. E.) Model KX. 12-39 X-Ray Unit Combination Radiographic and Fluoroscopic (200 ma.) with mobile control, tiltable table with Potter-Bucky Transformer and VCT Unit for floor mounting. (2) IGE L. W. R. T. Two units (each tube 200 ma) with lower contact board and contact brushes for the above, dual control HV cable 24' single blower tape assembly tube holder for L. W. R. T. Tubes, KX 20 Generating Unit, Tube Adapting Parts, Cable Support and HV Cable, Tube Stand and Stands for Chest Radiography. (3) Hand Fluoroscope. (4) Siemens Cardiostat (E. C. G.) Super Cat. No. 101-310. (5) Diathermy Instrument. (6) Ultratherm (for short-wave therapy) GR Ltd. Type E 601 No. 600. (7) Fedder's Air Conditioner 1 ton for the Dark Room. (8) Transformer 20 KVA - 400/230 to maintain supply voltage. (9) Godrej Refrigerator. All in tip-top condition. Intending buyers, if desirous of running the X-Ray Institute at Salem itself can have also, on lease, the spacious building in which the machinery is housed at First Agraharam, Salem. Persons interested are requested to communicate with Mrs. Ramaswami, No. 55, North Maravaneri Extension, Salem-7 or phone up Salem 2185.

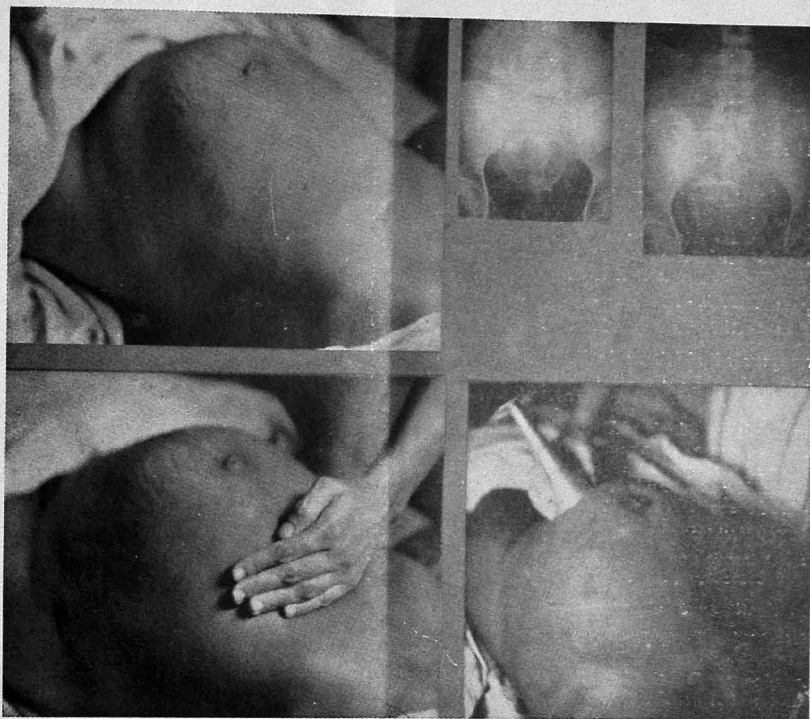


FIG. 2

(Courtesy — The Government Women and Children's Hospital, Egmore, Madras).

When examining a female patient with an abdominal swelling, one should employ every possible means to recognize pregnancy. Radiographic studies may prove to be a valuable aid.

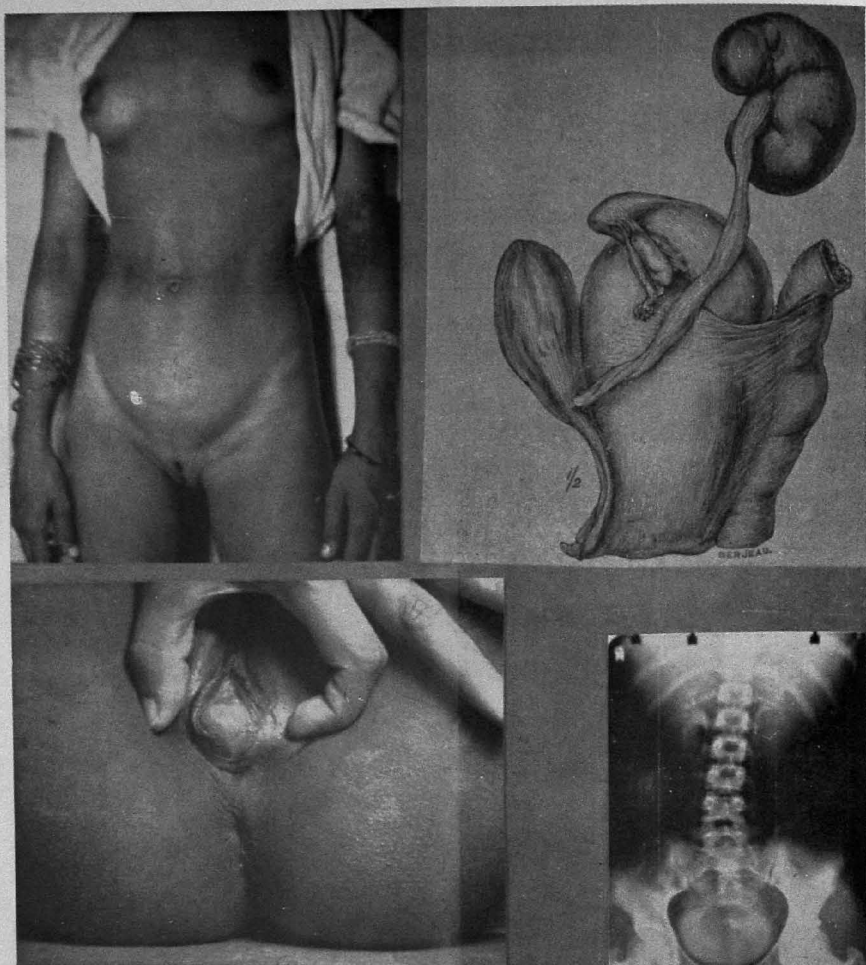


FIG. 3

(Courtesy — The Government Women and Children's Hospital, Egmore, Madras).

This 11 year old girl had attacks of retention of urine and an abdominal swelling persisted in spite of catheterization. Inspection of the vagina showed an imperforate vaginal septum to be present. Rectal examination confirmed the presence of a large swelling within the pelvis caused by distension of the vagina by contained blood. The uterus was felt as a nodule perched on the summit of the swelling. Intravenous urographic studies showed the urinary tract to be within normal limits. Under general anaesthesia the septum was incised releasing about 20 ounces of dark bloody liquid. The patient had an uneventful recovery and the vaginal orifice was kept patent by periodical dilations. Subsequent to the operation she had regular periods every month and never had any urinary difficulties.

The figure (top right) depicts a specimen in the museum of St. Bartholomew's Hospital, London. It shows the ureter compressed by a distended vagina. In patients with large or long standing haematocolpos urographic studies are valuable. Urinary tract abnormalities coexist in a significant percentage of cases with genital maldevelopment

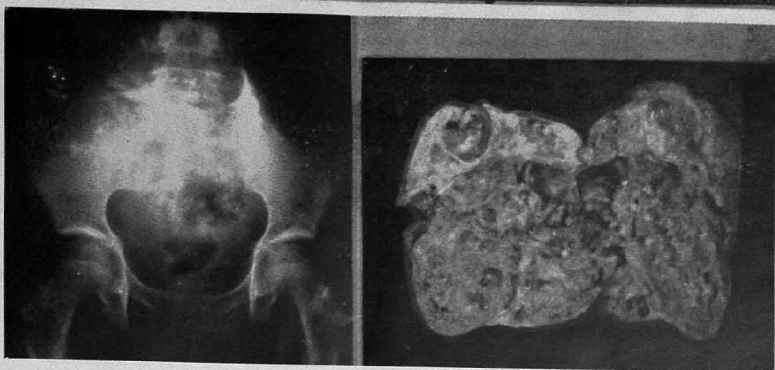


FIG. 4

(Courtesy — The Government Women and Children's Hospital, Egmore, Madras and Surgical and Medical News, Bombay).

A prepubertal girl aged 12, presented herself with an abdominal tumour reaching up to the umbilicus. It was hard and irregular. Terratoma was suspected and the preoperative x-ray of the abdomen showed irregular calcified areas. This diagnosis was confirmed at operation. The tumour which arose in the left ovary showed multiple cystic spaces, areas of haemorrhage and necrosis in addition to calcified areas made up of cartilage and bone.

Radiography is of great value in the diagnosis of certain abdominal tumours.

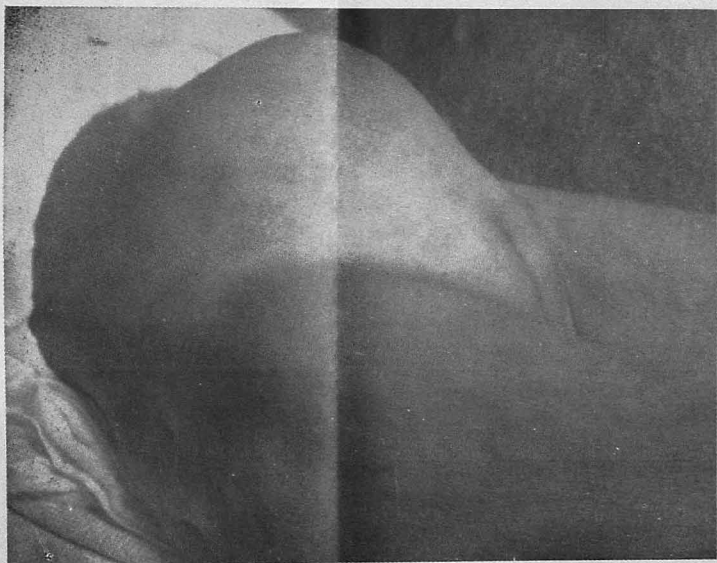


FIG. 5

(Courtesy — The Government R. S. R. M. Lying-in Hospital, Madras).

This 14 years old girl presented with an abdomino-pelvic tumour which proved to be dysgerminoma. When a solid tumour is encountered in a child or young woman one should think of dysgerminoma. The rare teratomas may be met with but they have a very different gross appearance. Granulosa cell tumour in prepubertal patients are characterized by precocious s-xual puberty changes. These are absent in dysgerminomas which although biologically inert are potentially malignant. The histological appearance is that of a large cell carcinoma. The cytoplasm is abundant, pale staining and translucent. The nucleus is large, round and stains heavily with haematoxylin. Mitotic figures are numerous. The cells are arranged in alveoli or rests with fibrous septa showing hyalinization and lymphocytic infiltration.



FIG. 6

(Courtesy — The Government Women and Children's Hospital, Egmore, Madras).

This patient was being treated for 'tuberculous peritonitis' with pelvic involvement for 'adnexal swelling' were palpated. She consulted a physician who performed a paracentesis for 'ascites' but evidently emptied only a locale of the tumour. Finding residual masses after tapping he referred the patient to a surgeon. An operation was performed with a provisional diagnosis of lymphosarcoma arising in lymph nodes. Laparotomy showed a large ovarian pseudomucinous cystadenoma which was benign. This was confirmed by histopathology study.

PREVENTIVE PEDIATRICS *

V. BALAGOPALA RAJU, M. D., D. C. H.,

Professor of Pediatrics, Madras Medical College, Madras.

Several years ago, when the department of pediatrics was fast developing in Madras at the expense of other departments like medicine, surgery and midwifery, one of the famous professors from America came to Madras and he was asked to address the Indian Medical Association, Madras branch. His subject was announced as preventive pediatrics. Some colleagues of ours from other departments spontaneously commented, of course in lighter vein, that the subject of great topical interest was not preventive pediatrics, but prevention of pediatrics. Even though it was in a lighter vein, this feeling that pediatrics is claiming more attention and space at the expense of other departments, especially medicine and obstetrics in an already crowded curriculum was a historic fact and caused irksomeness to and resistance from conservative physicians and obstetricians especially in England and naturally in India too. This could not be helped as pediatrics, though important, came very late into the well established British curriculum compared to other countries like U. S. A. and Europe and it has to develop to some extent at their expense.

What is pediatrics? It is care of children in health and disease - physical and mental. It includes medicine and surgery in all its various aspects, confined to a particular age group, that is from the new born to the adolescent. It is not all;

it is even something more than that. Preventive pediatrics is and should be a social science and should not be confined as a medical science, as it is a subject which deals with the science of bringing up children which is ultimately the responsibility of the parents. If we trace the history of the art of rearing offsprings in the whole mammalian kingdom including man, we find that this art of nursing and nurture has been imparted to succeeding generations by what we may call healthy primitive instincts. It is only with the advent of sophistication and civilisation in man, that some of these instincts tend to be forgotten. In recent times attempts are being made throughout the world to resurrect these instinctive practices and impart them to succeeding generations in the language of modern living conditions. This constitutes preventive pediatrics with training in mother-craft and father craft as its back bone.

This art of bringing up children, that is to let them grow and develop physically, mentally and emotionally at their own optimum pace and to avoid preventable physical, mental and emotional ailments is a very important aspect of pediatrics. Hence it becomes essential to teach this art not only to medical students but also to public health staff, para-medical personnel like nursing staff, medical and non-medical social workers, teachers and students in all schools and in fact ultimately to

* Paper presented at the 38th annual meeting of the Coimbatore District Medical Association on the 5th May, 1963.

every citizen of the country in a manner appropriate to each group. It will be worth while to have an historical concept of pediatrics at this stage to put the present day problems of pediatrics and to their prevention in the proper perspective.

Pediatrics as a separate subject was dealt with for the first time in recorded history by our ancient Indian physicians. In the book Kasyapa Tantra written years before the birth of Christ, there is a chapter on 'KaumaraMritya' - that is service to children. Susruta wrote a chapter on Koumara Mritya in the second century A. D. about the same time as Surneus in Greece wrote a treatise on children. For many centuries after Susruta, further knowledge in India on the care of children was limited to the accumulation of clinical observations and use of herbs and ayurvedic and unani drugs. In the villages and towns among practitioners of indigenous system of medicine, some were famous for their skill in treating children's ailments. In a way then through centuries there have been children's specialists at all periods of the evolution of the Indian history. Besides medicine, diet and dietetic restrictions, charms and incantations have been a feature in the traditional care of children in India. Though many of them were based on some sound principles in the beginning, most of such traditional methods of caring for children in health and sickness have deteriorated into systems based mainly on beliefs which do not stand even slight scientific scrutiny.

Similarly in ancient Roman civilisations, children received reasonable care and attention. In 318 A. D. the Emperor Constantine made infanticide a capital offence. Then

followed the dark ages - a period of chaos through which mankind groped its way with heavy toll in child life. In 1662, Captain John Graunt in his 'Bills of Mortality' stated that 36% of all babies born died before the age of 6 years and half the population was dead by the age of 12 years.

The 18th century in Europe and England saw the first organised attempts in child welfare - by establishment of foundling hospitals in England for unwanted infants who were often thrown away on rubbish heaps to die of exposure. During the next 2 or 3 decades, great interest was shown on the welfare of children and many treatises were published on child care. In 1769 George Armstrong published an essay on "diseases most fatal to infants" in which he criticised the common practice of blaming undiagnosed illnesses, on to teething and worms, the perennial scape goats, as popular then as they are to-day. At about the same time Underwood wrote an essay in which he also criticised the prevailing superstition on the dangers of teething. Teething produces nothing but 'teeth', wrote Underwood. In 1798 Jenner's introduction of cowpox vaccine for the prevention of small pox had a tremendous impact on infant mortality.

The 19th century has, with reason, been termed "the century of the child". Before this period, children had scarcely any legal significance. The first hospital exclusively for children was established in 1802 in Paris. The incredible fact was emerging in Europe and England that children were human beings. France which was the first nation to establish children's hospitals also took the lead in other spheres of child health, being the first to adopt

school medical inspection in 1842, and to establish the first creche in 1844. This wave of enthusiasm on the care of children spread to America and later to England, where several institutions sprang up for infant health services. In 1905 Mcleary established the first baby clinic in England, a bare 58 years ago.

In India modern pediatrics started in 1920 on the lines of British pediatrics as it was in vogue then, i.e., child welfare centres on one side, and a few of our physicians turning to pediatrics as a speciality. However, most of the pediatrics was confined to the curative side with practically little or no preventive counselling. Till very recently, maternity and child welfare centres looked after only the maternity work and none of child welfare work.

In 1948, the first chair of pediatrics was created in Madras with Dr. Achar as the professor, even though there were pediatric departments and pediatricians of repute in Bombay, Calcutta and a few other centres. The problem of pediatric care of sick children were so enormous that the few departments of pediatrics which were started in some medical colleges were mainly concerned in giving better medical care to very sick babies. At present, rightly there is a wave of enthusiasm for proper care of children and a tremendous awareness among the government policy makers and many voluntary organisations and philanthropic agencies of the importance of child health. Time and climate are propitious to channelize all these enthusiasm in order to achieve the desired goal with minimum effort and maximum results.

Let us first be clear of what this child health exactly means. Many

of us are under the impression that child health means absence of disease or illness in the child. In a land riddled with poverty, procrastination, perspiration and parasites of various kinds, the prevention of sickness in a child is by itself a very important advancement towards the goal of achieving child health, but it is not the goal itself. If the health of a child is thought of as a continually shifting point on a vertical scale, divided sharply into "health and sickness", a more clear understanding is possible:

Health	Optimum health
	Moderate health
	No actual illness
Sickness	Clinical illness
	Severe illness
	Death

Clearly an individual child or adult at his optimum state of health is much more fitted to stand the strains and stress of various kinds, including an infection than the one who is but a fraction removed from actual clinical illness. It is within the experience of each one of us to have been while at or near our optimum health, exposed to say the virus of influenza, and later to have remarked, "I thought I was coming down with flu, when all in my family had it, but I somehow seemed to have shaken it off". What happened of course was that the shifting point of one's health level dipped sharply, as a result of the infection of the flu virus, but starting high up the scale, did not dip low enough to produce clinical illness. Hence it should be our goal not only to prevent illness in a child, but also to maintain his individual health level as near the optimum as possible. In other words every child should have some reserve health potential, i.e., what is meant by

the term and by promotion of positive health. This is the ultimate goal. Having a clear vision of the goal, let us see the starting point, i.e., where we stand now and how are we advancing: In other words:

- (1) What is the nature and extent of our child health problems.
- (2) What are they due to.
- (3) How are we to overcome most of them with our present set up.
- (4) What are the long term plans for the promotion of positive health.

It has been said that the only value in looking backward in studying history is to enable one to see ahead more clearly. From the historical review, it is apparent that the lot of the children of the world till the turn of the present century had been appalling. However, during the past 3 or 4 decades, in all of the industrialised countries in Asia, Europe and America, the preventable mortality and morbidity in children have been brought down almost to the minimum. This has been possible mainly by industrialisation, protected water supply, better environmental hygiene, and education, especially health education, on child nutrition and nurture and to immunization programmes.

Now let us look briefly at the conditions in India to-day:

- (1) Nearly 40 percent of our population are children (whereas only 15% of population in Western countries come under childhood age group). Dr. Cicely Williams who worked for over 2 decades in the tropics - aptly said, that the principal disease group in the tropics is childhood.

Now what happens to this enormous number:

- (2) Nearly half of them die before they reach adulthood. You may remember that I said a few minutes ago that in 1662 in Europe 36% of all babies born died before the age of 6 years and half the population by the age of 13 years. We do not yet seem to have improved much upon this state of affairs which existed 3 centuries ago in Europe.

An argument may be advanced that this enormous mortality is necessary to bring down our population which is explosive to say the least. But then the conditions and environment which produced one mortality has also produced dozens of morbidity among children who are a tremendous drain on the resources of society. So this is not an alternative to family planning.

- (3) During 1959 in Madras city alone there were 33,501 deaths of whom 53.5% were in children below 5 years of age (Madras corporation figures). They are all Madras city children born in hospitals or maternity homes, had an army of general practitioners and doctors, including specialists in the hospitals to cater for their sickness. This, in spite of so many child welfare centres, 6 big medical college hospitals with pediatric departments, scores of privately run charity hospitals like the Jain hospitals. I want to drive home this point with regards to the mortality figures.

What about the morbidity figures:

We have practically none except that we in the department have started a follow up study of several thousand families over years now in our pediatric peripheral clinics. The figures are not analysed yet. But I can confidently say that 90% of children attending hospitals in Madras for

minor illnesses like U. R. I., mild diarrhoea, etc. have evidences of malnutrition and or other chronic illnesses. Another indirect evidence of enormous morbidity was, when we found that the crowd of patients in the general hospital children's department was unmanageable, over 500 children to be seen in 3 hours' time, we expected to reduce this load to some extent by opening 4 peripheral pediatric centres in the areas from where the bulk of our children were coming. We staffed them with our own doctors and gave even better attention and drugs (with Unicef and WHO help). These clinics became popular and attracted large crowds of children. But yet there were no signs of any lessening of the crowd in the general hospital pediatric O. P. We were amazed and wondered where from so many sick children came. When we visited other corporation children's centres and Jain dispensaries, the crowds of children were equally appallingly large. Then realization came to us that the morbidity among children is so universal, that any number of hospitals catering for children, any amount of drugs like penicillin, streptomycin and other antibiotics and drugs, will not in any significant way reduce appreciably the morbidity and even mortality in children. What about the rural areas? The conditions are no better, as we shall see later on.

Now what are the main causes for this colossal morbidity and mortality;

1. Malnutrition - either as a primary or secondary cause due to some illness or other.
2. Acute and chronic infections and infestations - many of them due to lowered resistance as a result of malnutrition and poor environmental hygiene.

Next let us consider why there is so much of malnutrition and preventible infections among our children :

It is customary to blame economic factors and over crowding for this malnutrition and infections which is almost universal in our country. Even though these play a considerable part directly or indirectly, ignorance of the simple rules of hygiene and child care are equally responsible. In a field survey conducted by me 10 years ago in about 9 villages, it was found that nearly 66% of children had signs of malnutrition of various grades. Of these nearly 75% could have had an optimum diet, if only parents knew what to give from the locally available nutritive foodstuffs (Child health services in rural areas - Report of talk during the All India Pediatric Conference published in the Indian Journal of Pediatrics Vol. XIX No. 76 Oct. 52). Nowadays there is improvement in the overall earning capacity of all classes of people and also we have newer and better knowledge of the locally available "low cost" food stuffs. The time has come for a coordinated drive to eradicate the wider problem of ignorance of child nutrition and care. The general administration is directly responsible and is trying to improve the economic condition of the people with series of 5 year plans. The medical men should bear more direct responsibility along with the public health and education departments for a coordinated and successful attack on the enormous problems of ignorance of child care, i.e. ignorance of the medical men themselves, and public health personnel, para-medical personnel, non-medical voluntary social workers and masses in general about the simple rules of child rearing and nutrition.

The training of medical undergraduates and post-graduates in pediatrics is only solving a part of the problem. That is why the definition of preventive pediatrics as a purely medical subject is not complete in the present context in Madras or in fact in the whole of India. In a large measure, preventive pediatrics should be a social science which should be taught in all the schools and colleges and in fact this knowledge should permeate to every citizen of the country.

In Madras state this could be achieved by the following means :

(1) Vigorous short term reorientation of the general practitioners, doctors especially of primary medical and health centres and public health personnel on the health needs of children and their role by intensive refresher courses. An attempt on these lines is already being made by the Institute of Pediatrics, Madras Medical College, Madras under the direction of Professor S. T. Achar.

(2) Set up of training of paramedical personnel in nutrition and preventable infections especially with regards to children and knowledge of locally available nutritive food stuffs suitable for children.

(3) By periodically sending circulars in Tamil and using other means of communications like films, lantern slides, posters, etc. (prepared by the public health and pediatric staff) to schools, public health workers, social welfare organisations and general practitioners, on epidemics and endemics of topical interest and also on various aspects of child care.

(4) Stepping up of statewide immunization programmes — It is very gratifying to record that the Madras corporation is implementing free triple immunization programme

against diphtheria, tetanus and whooping cough to all children attending their welfare centres.

Particular emphasis must be laid on another view point which is somewhat controversial, i.e. ; with regard to the mental health problems. Many feel that in the prevailing conditions in India at present, the time devoted on mental health problems is too much of a waste. Perhaps they are largely true.

But we are now at the same evolutionary stage were most of the now technologically advanced countries found themselves at the turn of the present century. They also had at that time mental health problems as we have now, masked by widespread physical illnesses due to malnutrition infections. We have to gain from the experiences of these countries who are now saddled with a heavy load of mental health problems after conquering most of the physical illnesses. Hence we should not neglect to emphasise the mental health requirements also from now on and to take steps simultaneously to detect the early abnormal psychological traits in children and to prevent the increasing incidence of juvenile delinquencies and other mental illnesses many of which are the results of unsatisfactory social and family environments during early childhood.

The variety and enormity of the problems are apparently perplexing. But with proper perspective we can see that a very great proportion of these problems can be and should be tackled even now with our present resources and personnel. This may be achieved as stated already by working out a cohesive health education plan for all classes of people with the co-operation and coordination of the public health, medical and education departments of each state.

Role of the general practitioners and others caring for children :

Many of us doctors, like Hanuman of Ramayana, are not aware of our own potentialities to influence the public opinion in India. The common man of India today is only too willing to follow the advice given by his doctor especially with regard to his sick child, whereas the same man will dodge a vaccinator or any member of the health staff whose duties are less dramatic though as important if not more in the long run. Well baby clinics which were started in many centres in India imitating the west is, in our opinion, largely a failure. Because our people are still not psychologically ready to take a "non-sick-child" to any clinic whatever be its name, or to a doctor. Our attempts at improving the child's health will be successful only if we use the sick child as the pivot, curing and thus gaining the confidence of the mother and give her proper advice for the care of the child. This she will certainly follow. This is the principal philosophy behind our peripheral pediatric clinics in Madras. These clinics are very successful in the dissemination of health knowledge about children in the areas they serve. Every enlightened general practitioner can convert his private clinic or dispensary into "sick cum well baby clinics" and devote a few extra minutes in giving advice to the mother about immunization, proper food for the baby after the illness is cured, etc. Most practitioners are doing it even now in a way, but by a conscious effort one will be able to do a lot more. After all a large bulk of the practice is willy nilly among children.

I shall briefly indicate the type of advice you can give and which will I am sure also spread from parent to

parent, as our women folk do not lag behind their counterparts in other countries with regard to passing on interesting information.

Many of the mothers with malnourished children simply do not know what is the right food to give which is well within their financial resources. Mothers often ask many common doubts regarding feeding. Also many educated mothers ask about immunizations. I shall enumerate some such questions and answers. It is not complete, but will indicate how simple answers to such questions could reduce the morbidity and even mortality of many of our children. For example, let us start with what the child needs for physical well being: (1) Food (2) Prevention of infection during first few months of life.

Food : (i) What is the best food for infants—of course breast milk. Simple and silly this answer sounds. But when one sees the decline of breast-feeding in the west and some pediatricians abroad and even in India talking about tinned milk foods being equal, if not even better, than breast milk, this answer seems to be important. There is a tendency nowadays to resort to artificial feeding at the slightest pretext.

(ii) Suppose there is no breast milk, how much cow's milk should a baby get. Here again the common error is too much dilution. Formulae calculated on the calories may be good to teach students but not in practice. A simple rule is to give the baby as much as he wants so long as dilution is taken care of; upto three weeks of age, dilute cow's milk and water in equal portions. From 3 weeks to 4 months of age, 2 parts of milk and one part of water. From 4 months to

6 months 3 parts of milk and one part of water. After 6 months undiluted cow's milk.

(iii) Sugar one teaspoon for each 3 ounces of milk.

(iv) What about tinned milk foods. Common errors are: (a) They are prescribed too often to people who cannot afford; so they dilute it more, as if it is a magic tin.

(b) Even mothers who can afford, give tinned milk more dilute as they feel the instructions on the tin are for western babies and that our babies may not stand such full strength formulae.

(c) Unfortunately many tins have instructions that no feed should be given after 10 P. M. This is wrong in principle. Even if the baby needs one or two feeds after 10 P. M., it should be given.

(d) Sweetened condensed milk is too popular among the rural folk. It contains too little P and F and too much CH_3 and should not be used for infant feeding.

(e) When should vitamins be started: There was a time when no vitamins were given to babies. Now many obstetricians at any rate in Madras feel it is fashionable to prescribe vitamins before the baby leaves their care i. e. they start babies on vitamins from 7th day of birth. It is wrong. Vitamins should be given only at the end of a month in artificially fed babies and at the end of 2 months in breast fed babies.

What Vitamins? Vitamins A, D and C are essential.

What are the sources of Vit. A & D? Shark liver oil or cod liver oil or other preparations containing A. & D. in which you are all familiar — one to 2 tea-spoons a day. Those

who can afford, 6 drops per day of any multivitamin drops and 10 drops per day after 2 years of age.

What are the sources of Vitamin C? Orange juice, tomato juice and Vit. C tablets for small infants. Also gooseberries (amla) and other raw fruits for older children. For babies from low economic strata who cannot afford fruit juices, the following advice may be given:

Bring to boil half a tumbler of water. Add a handful of freshly plucked and washed drumstick leaves, keep it on fire for one or two minutes, remove and leave it aside for 10-15 minutes with the lid closed, mash it and extract the juice and give. This will satisfy fully the Vit. C requirements for growth and maintenance.

When should solids be started for the babies? Generally round about 4 to 6 months of age. Common error is to start solids late.

What solids are to be given? Iddli mixed with milk and sugar or butter-milk and salt. Idiappam with cow's milk and sugar, well mashed rice with well boiled dhal or with rasam, curds or even with well-mashed green leaves. Ripe and mashed plantains are also good. Soft boiled egg yolk and fish may be given by those who can afford. Well-boiled minced meat can be added round about a year or even earlier.

Suppose there is no milk available for the baby after 6 months: What is the cheap milk substitute?

Bengal gram kanjee-puffed, roasted and finely powdered Bengal gram 8 teaspoons to an ollock of water with 3 teaspoons of sugar, preferably brown sugar, boil water and dissolve sugar (filter if necessary) and then

mix the Bengal gram powder in the warm sugar water and feed. This is almost equivalent to one o'clock of cow's milk as far as body building proteins are concerned — (it gives much more energy than milk).

For older children :—

Bengal gram boli (செந்நெய்)

Bengal gram wheat dosai

Bengal gram (செந்நெய்) etc. may be used.

“Do's and Dont's” :

1. Do not give castor oil or any laxatives as a routine to infants, because constipation is almost always due to under feeding.

2. Gripe water does not serve any useful purpose.

3. Small babies feel thirsty as much as others, and water should be routinely offered in between feeds especially during hot days and when the child is having diarrhoea.

4. It is important to wash hands and boil the bottle and other vessels used for feeding.

5. Coffee and tea should not be given to small babies.

Next what are the immunizations that should be done for all babies ?

1. Small pox vaccination at the 3rd month.

2. Triple immunization (against diphtheria, whooping cough and tetanus) at the 4th, 5th and 6th months (one injection each month IM) and again at $1\frac{1}{2}$ years and 5 years. (1st and 2nd booster, one injection each).

3. Salk vaccine against polio at the 7th and 8th months and the 3rd injection, 6 - 7 months after the second.

4. It is better to give B. C. G. vaccination at birth itself or at any other convenient time, if Montoux test is negative.

So far, we have considered some of the basic necessities for physical well being. What are the basic needs for the mental well being (emotional food) which is as important as the physical well being of children ? These are the things which our great grand-fathers knew and followed and which we are to re-learn in modern time :

1. Love: Every child needs to feel that the parents love, want and enjoy him.

2. Acceptance: Every child needs to believe that his parents always accept him, even though they may not approve of every thing he does.

3. Security: Every child needs to know that his home is a good safe place he can feel sure about.

4. Protection: Every child needs to feel that his parents will help him when he must face strange, unknown and frightening situations.

5. Independence: Every child needs to know that his parents want him to grow up and have confidence in him.

6. Faith: Every child needs to have a set of moral standards to live by.

7. Guidance: Every child needs to have friendly help, i.e. how to behave towards persons and things.

8. Control: Every child needs to know that there are limits to which he is permitted to go and his parents will hold him to these limits.

In conclusion I would like to suggest a tentative plan for the over all care of children of an industrial city like Coimbatore.

Coimbatore is unique in many respects and if there is an ideal place to start a scheme for the total care of children, it is Coimbatore.

1. Coimbatore is an industrialised area.

2. The economic condition of the people here is comparatively better.

3. This place does not lack doctors.

4. There are many philanthropic minded people among the rich here and money will flow for a just cause, if they are convinced of the goodness of the cause for which they are asked to contribute money.

5. It is not too big a city with a huge floating population, too many slums, too many hospitals, and too many specialists as in Madras to make a coordinated effort more difficult.

In the beginning you can start the scheme for the city and afterwards extend it to cover the district also.

(1) *Citizens Child Health Council* may be started with a committee consisting of pediatricians, general practitioners, health officers representatives of the municipality and teachers and a few prominent citizens.

(2) *Collection of some basic data* on local causes of morbidity and mortality by a team of health and medical staff. This need not be elaborate. Even a questionnaire sent to all doctors regarding common problems in children they meet with in their daily practice will give most of the needed information.

(3) *Collection of funds*: The plan itself in general will include registration and recording of all births which of course is already being done.

(1) Examination of all babies within the first 6 to 8 weeks of birth.

(2) Examination again at one year and at 3 years — the most vulnerable period of a child's life in India.

(3) School medical inspection at the beginning, once in the middle and lastly at the time of leaving the school.

These three may be done with part time help of all the doctors of the city.

(4) You could devise details of the methods of health education technique to various classes of people and to children in schools. This may be done by orientation classes to teachers by the medical men, by printing in Tamil and issue of pamphlets on infant and child nutrition, on methods of prevention of infections, and by posters and advertisements on the screen. Once the scheme is started ideas will flow and you will yourselves improve and improvise various techniques. The field and the possibilities of improving the lot of children are enormous and with little effort we can bring down the mortality and morbidity of the children in Coimbatore to half of what it is today.

It is my fervent wish that this city should be the torch bearer for such a noble venture. In all humility I would like to offer my services if requested in whatever capacity you may need them for the details of working of this plan.

ABSTRACTS AND EXCERPTS

MISMANAGEMENT OF URETHRAL CATHETER :

Catheterization is required for :

1. Drainage of obstructed or paralytic bladder.
2. Drainage of bladder after injury or after surgical treatment of the urethra, prostate, bladder, and contiguous organs such as the rectum, uterus and vagina.
3. Performance of cystometrographic and cystographic tests and measurement of residual urine.
4. Procurement of a completely accurate urine sample.

Failure to catheterize a patient who requires drainage can lead to serious complications and even at times death. The undrained bladder can cause renal functional impairment and infection. Drainage of a poorly emptying and infected bladder cavity is equivalent to evacuating an abscess cavity.

However, discrimination in selection of patients is essential. Catheterization is never an alternative to good nursing care. Catheter drainage is sometimes prescribed, for elderly patients in particular to facilitate the work of the nursing staff.

Complications : Complications of catheterizations can be prevented by atraumatic and aseptic handling of a well-lubricated catheter of appropriate size and by subsequent aseptic management throughout the drainage procedure. Trauma to the mucous membrane and infection, the main complications, result from improper technic.

Trauma may be due to forceful introduction or to abrasive action of a poorly lubricated rubber surface. The injury can lead to immediate discomfort, bleeding, creation of false passages, or even perforation of the urethra. Invasion of bacteria through the injured areas results in local infection and blood stream contamination.

Technic of catheterization : If the urethra is practically sterile, entrance of bacteria can be prevented. Adequate periodic cleansing about the meatus in males prevents the entrance and multiplication of bacteria.

Before the catheter is introduced, the area of the meatus should be carefully washed with a surgical detergent containing hexachlorophene. Then a quaternary amine such as Zephiran is used, and irrigation within the meatus for a short distance is accomplished with an Asepto syringe.

A size 12 to 16 F catheter is employed. Passage should be gentle, using an instrument or sterile gloves. In women, the labia must be well separated at all times to avoid contamination.

If the catheter is to be left in place, sterile drainage apparatus is attached. The adapter from the catheter to the drainage system must be of adequate size; a common source of contamination is a small adapter which easily becomes separated from the catheter. The catheter should not be disconnected without thorough cleansing of the junction with alcohol.

Irrigations are performed with rigid precautions against contamination, using a fresh sterile set each time. When the urine is grossly purulent or epithelial debris is considerable, intermittent irrigation with a syringe or closed system and an acidifying or bacteriostatic solution may be helpful.

When voiding is abnormal after removal of the catheter, the cause must be determined, whether infection, obstruction, improper bladder function or a combination of conditions.

— *Modern Medicine of Canada.*

* * * *

PREVENTION OF POSTCATHETERIZATION INFECTION:

Administration of sulfonamides after catheterization reduces incidence of bacteriuria and risk of urinary tract infection.

Catheterization was done immediately before and seventytwo hours after delivery in 448 women. Placebos were given to 221, and 227 were treated with 1 gm. of Orisul or Thiosulfil four times a day, beginning immediately after delivery.

In the control group, 120 patients had sterile urine at both catheterizations, as compared with 144 in the treated group. Of the controls, 66 had sterile urine at the first catheterization but not at the second. Only 37 of the treated patients with sterile urine at the first catheterization had second cultures that showed bacteriuria.

— *John H. Davis, Jerold M. Rosenblum, Edward J. Quilligan and Lester Persky, (Western Reserve University, Cleveland, and University Hospitals of Cleveland). An evaluation of post-catheterization prophylactic chemotherapy. J. Urol. 82:619-616, 1959.*

* * * *

CONIZATION OF THE UTERINE CERVIX:

Experience of conization of the cervix in the diagnosis of cervical carcinoma is reviewed. At the University Women's Clinic, Freiburg (West Germany) this procedure was performed in 281 cases; surface carcinoma was diagnosed in 232. The method is greatly preferred over simple biopsy-excision. Conization of the uterine cervix is now performed in up to 100 cases per year.

The method is employed when at least two cervical smears have given positive cytological results or colposcopy has shown suspicious changes, with or without initial punch-biopsy. Benign changes were found in only 3.7% of conization, while advanced carcinoma was present in 14%. Conization with a knife is preferred to excision by electro-conization.

In one-third of cone-excisions including cases of surface carcinoma, the malignant process had spread beyond the area of excision. Continued growth is likely to occur in one-third of these. However, a long latency period before the malignant process spreads is to be expected. This gives time for additional treatment, which must be fitted to the local findings and the age of the patient.

Normal conception and birth are quite possible after conization, but disorders of cervical function are likely if the excision was very extensive. The procedure is a major surgical intervention requiring on an average 17-20 days of hospitalization.

— *German Medical Monthly*", Vol. VIII, No. 1, pp. 29 & 30.

* * * *

FILARIAL ENCEPHALITIS (A Case Report):

The patient was a Hindu student who had been ill for 2 days with fever and rigors and unconscious for 8 hours before he was seen in hospital where microfilariae were found in large numbers in the blood. There was rigidity of the neck and a bilateral extensor plantar response. The patient's condition improved over a period of 2 weeks on treatment with diethylcarbamazine (Hetrazan) but deteriorated immediately the treatment was stopped. On resumption of the drug there was again improvement and eventual complete recovery.

— *Pande, R. S., J. Ass. Physicians India, 1962, Sept., V. 10, 469-71.*

* * * *

ADMINISTRATION OF MAXIMUM DOSES OF CHLORAMPHENICOL:

Due to the publicity and emphasis that has been placed on the toxic effect of chloramphenicol on the hemopoietic system, and discussion of the use of this antibiotic in high dosage must start with this point. The two separate types of hemopoietic toxicity that have been reported are aplastic anemia and the finding of reversible vacuolation in cells of the bone marrow during therapy. This latter finding was associated with low reticulocyte counts and mild anemia.

In view of the very low rate of the aplastic anemia toxicity, it is not unexpected that in the 95 cases in this report, and in hundreds of other cases treated in this manner with chloramphenicol, we have never encountered a case of aplastic anemia,

The more subtle reversible bone marrow toxicity discussed by Rosenbach, Caviles, and Mitus (New England J. Med., 663, 724, 1960) and Saidi, Wallerstein, and Aggeler (J. Lab. & Clin. Med., 57, 247, 1961) may well have occurred in some of our patients and not been revealed by the studies that were done. Even if this were the case, in no instance did the administration of chloramphenicol appear to do permanent harm to the patient. On the other hand, withholding the chloramphenicol because of fear of hemopoietic toxicity, undoubtedly would have ended in some fatalities. Thus these data support the opinion of many other authorities that chloramphenicol should not be denied, on the basis of fear of hemopoietic toxicity, to patients who may need it. The data further suggest that increasing the dosage of chloramphenicol can be done with relative safety in patients whose illness justifies this step.

It should be noted that when Krakoff, Karnofsky, and Burchenal (New England J. Med., 253, 7, 1955) gave high doses of chloramphenicol to 4 carcinoma patients in 1956, three developed severe glossitis and one had bone marrow depression. All of the patients in our series received 1000 ug. of B₁₂ and 5 mg. of folic acid daily because of previous experience that this prevented antibiotic glossitis. It is possible that these vitamins, given in large doses, may in some way have prevented bone marrow toxicity as well as antibiotic glossitis. This possibility is further suggested by Gussoff, Lee, and Lichtman (Arch. Int. Med. 109, 176, 1962) who recently confirmed the finding by Saidi *et al.* of vacuoles in the red cell series of the bone marrow, and suggested that they were due to folic acid deficiency.

The use of gamma globulin in many of the patients is consistent with the thesis of maximum tolerated therapy, but no attempt was made to assess its particular value in this group in view of other confirmatory studies. However, the excellent toleration of gamma globulin given by the intravenous route (dissolved in 500 ml. of fluid) in 30 of the patients is worthy of comment due to the fact that its labelling interdicts usage by this route. Reason for this is not clear, but it may have been based on the opinion of Gross, Gitlin, and Janeway (New England J. Med., 260, 170, 1959) for which we can find no confirmatory data. In the administration of gamma globulin to hundreds of patients we have seen only one generalized reaction and that was after an intramuscular injection in a patient who previously had a slight reaction to an intramuscular injection.

In a sense it is unfortunate that it was necessary to select a controversial drug such as chloramphenicol to test the thesis of highest tolerated dosage because this might tend to obscure the main point, that in therapy of infectious disease, drugs may have to be given to the point of toxicity before a clinical response is obtained. In other situations, such as the chemotherapy of cancer and the use of corticoids in lupus nephritis, this philosophy seems to have been more generally accepted.

Summary and conclusion: Ninetyfive patients with severe bacterial infections were treated with the highest tolerated dosage of chloramphenicol and other drugs. Analysis of these cases revealed no toxicity from total

doses of chloramphenicol that averaged 64 gm. The high dose regimen often gave satisfactory results after failure with moderate doses of antibiotics. These findings suggest that in severe infections the maximum dosage of drugs consistent with the nature of the disease, the toxicity of the drug, and the conditions of the patient will often be of benefit when lesser measures fail, and that chloramphenicol is a relatively safe antibiotic for use in this manner.

INFECTIONS TREATED WITH HIGHEST TOLERATED DOSES OF CHLORAMPHENICOL

Diseases	No. of patients	Survivors
Postoperative wound infection (Staphylococcal)	... 10	9
Severe burns	... 16	12
Staphylococcal bacteremia	... 14	10
Staphylococcal osteomyelitis	... 12	12
Pneumonia (Staphylococcal, Friedlander's, undiagnosed)	7	4
Abscesses (Abdominal, pelvic, lung)	... 15	14
Peritonitis	... 6	6
Meningitis (Staphylococcal or hemophilus)	... 5	5
Endocarditis (Staphylococcal or undiagnosed)	... 3	1
Staphylococcal cellulitis	... 5	5
Staphylococcal enteritis	... 2	1
Pyelonephritis	... 10	9
Salmonellosis	... 1	1
Total	... 106	89

* Total is greater than 95 because some patients fitted into more than one category.

The usual initial daily dose of chloramphenicol given to adults was 8 gm., dissolved in 500 ml. of 5% dextrose in water. The mean total dose given to the 95 patients was 64 gm. The highest total dose, which was given to case 1 of the case reports (multiple brain abscesses), was 357 gm., and the lowest total dose was 9 gm., given to a 3-year old girl with staphylococcal bacteremia.

— 'Waisbren, B. A., M. D., et. al.' *The American Journal of the Medical Sciences* 245, pp. 2-(1963).

*

*

*

*

IMMUNIZATION AGAINST POLIOMYELITIS:

Last year there were 331 cases of acute poliomyelitis in England and Wales, the lowest number for many years, and there is little doubt that the immunization campaign which was begun in 1956 played a major part in bringing this about. Although this is most encouraging it is by no means satisfactory, and it should be possible by a more intensive campaign to reduce the incidence of the disease still further. Immunization against

poliomyelitis should aim not only at protecting the individual but at establishing a community immunity which should lead to the complete eradication of the disease as well as the causative viruses.

Many experts believe that the Sabin oral vaccine, when used on a wide enough scale, can bring about this state of affairs. As pointed out in a leading article eighteen months ago, Sabin vaccine is able to produce not only a substantial humoral immunity, as shown by the presence of circulating antibodies, but also a resistance of the intestinal tract to infection. This latter type of immunity, when vaccination is on a wide scale, is highly important in breaking the chain of transmission of infection and in leading to elimination of the poliomyelitis viruses from the population. In this respect the live Sabin vaccine has an advantage over the dead Salk vaccine used in Britain during the last few years: Although Sabin vaccine is effective in protecting the individual from the paralytic disease the intestinal tract of the immunized person remain relatively susceptible to infection, unless the vaccine is of high potency.

It was thus a wise decision to permit local authorities and family doctors to change over from Salk to Sabin vaccine in Britain in 1962, when supplies of Sabin vaccine became available. To achieve the most effective results, however, the immunization programme should be on a mass scale, paying special attention to young children, who are the most active spreaders of the poliomyelitis viruses. It is questionable whether the efforts to protect the population of Britain against poliomyelitis are comprehensive enough. Programmes in many other countries are highly organized. In Czechoslovakia, for example, more than 90% of children under 14 years of age received vaccine in 1960 and a similar number in 1961, and this has led not only to the complete suppression of the disease but also to the disappearance of poliomyelitis viruses from the population. It is true that plans in Britain were complicated by the change over from Salk to Sabin vaccine, when separate schemes were used in order to complete the immunization of those who had received 1, 2 or 3 doses of Salk vaccine. It should now be possible, however, to embark on a simplified scheme which would have greater possibility of success.

— *Editorial: 'British Medical Journal' March 9, 1963. P. 623.*

* * * *

EPIDEMIC OF POLIOMYELITIS IN PUERTO RICO, 1960:

Puerto Rico experienced the most severe outbreak of poliomyelitis of any occurring in the Western hemisphere in 1960. The 495 paralytic cases represented one of the largest epidemics in the island's history.

The epidemic began in late January, reached a peak in mid June, and then declined during the late summer and early fall months. No seasonal pattern of poliomyelitis has been established in Puerto Rico.

Type one poliovirus was identified early in the widespread epidemic, which involved 68 of 76 municipalities. The initial cases occurred in late January and were followed by a radial spread with first Ponce and then the San Juan area serving as focal points.

The age distribution was predominantly infantile; approximately 90 per cent of the cases occurred in children under 5 years of age. There was a greater proportion of cases among males; highest attack rates occurred in the age group 6 to 11 months. Eighty-three percent of the cases were in unvaccinated individuals; only 6 per cent were in persons who had received three or more doses of Salk vaccine.

The disease was found to be relatively mild in the younger age groups with little bulbar involvement. Among the few adult patients, the disease was very severe.

Special studies in San Juan, the capital and largest city, demonstrated the highest attack rate in the lower socioeconomic segment of the population. The effectiveness of Salk vaccine, adjusted for age and socioeconomic status, was found to be 82 per cent for three or more doses.

— R. A. Timothee & others, *Public Health Reports*, 78, 65-76 (1963).

Dr. C. S. THAKKAR ORATION AWARD

Further to the preliminary information given in these columns concerning the Dr. C. S. Thakkar Oration Award of the I. M. A. to be instituted at the ensuing 39th All India Medical Conference, 1963, to be held at Madras, the following further details relating to the Award are published for the general information of all members of the I. M. A. and for the information of intending competitors for the Award:

1. There is no limit to the number of persons competing for the Award, who should submit at least 6 typed copies of the paper to be read by them by 1st of September to the State/Territorial Branch Office, so as to reach the Journal latest by the 31st of October, with a copy of the paper to the Headquarters Office by the same date.

2. Since the Award has been established recently and no orator has been chosen, the criterion for sending recommendations by the state branch would be based on age, experience, status in the profession and original work done by the individual which has not been published before.

3. The selection of the orator would be finalised by the Journal Committee before the 15th of November from amongst all the competitors whose names and papers had been duly forwarded by the state council recommending their own views on the priority to be given for the paper.

4. The oration would be delivered on the occasion of the inauguration of the scientific session and the Award would be given just before the oration, when the orator is being introduced.

Intending competitors are, therefore, requested to send eight copies of the paper to be read by them to the hony. state secretary, Madras state branch of I. M. A. 63, Swami Naicken Street, Chintadripet, Madras-2, by registered post acknowledgement due, so as to reach him by the first of September 1963, so that the matter may be considered by the State Council of the Madras state branch of I. M. A. at its meeting to be held in September 1963.

ASSOCIATION NOTES

BRANCH NOTES

Coimbatore Branch:

1. A 'Picnic Run' was arranged on 22—12—1962 for the benefit of the members to visit the Synthetic Gem Factory and South India Viscose at Mettupalayam. The members numbering about fifty gathered at the association premises at 1 p. m. Dr. Anna Vareed, president gave a brief account of life and achievements of Dr. M. G. Nair and his sad demise at Singapore. A condolence resolution was passed and the members observed silence for 5 minutes to mark his memory. The resolution was forwarded to the members of the bereaved family.

The party then started to Mettupalayam by car, visited the Synthetic Gem Factory and South India Viscose Ltd. at Sirumugai. The authorities of the factories arranged to show and explain the working of their factories in detail and later the members had tea at South India Viscose Ltd. in the Staff Recreation Hall.

2. A monthly meeting of the Coimbatore District Medical Association, branch of the I. M. A. was held on 26—1—1963 at 6 P. M. It was a combined meeting of the Coimbatore and Palghat branches of the I. M. A.

Dr. Mrs. Anna Vareed, president, welcomed the members of the Palghat branch and later a condolence resolution touching the death of Dr. K. V. Subramaniam, B. S. Sc., L. M. & S., was passed with members observing silence for 2 minutes.

Dr. A. G. Leelakrishnan was elected unanimously to represent the Coimbatore District Medical Association in the general body meeting of the Coimbatore Co-operative Printing Works, Ltd., for three years.

Dr. K. S. Venkatachala Iyer, president of the Palghat branch, suitably replied on behalf of his branch. The president introduced the speakers, Drs. N. Subramaniam, P. R. Subbian, C. H. Sivaraman and N. S. Ramamurthy, who were to speak on the subject 'Acute Heart Attack'. Dr. P. K. Kalyanaraman was requested to be the moderator for the symposium. Giving a short introduction on the subject and about the speakers, Dr. Kalyanaraman called on the speakers to speak on the topics allotted to them. Started by Dr. N. Subramaniam who spoke at length on the physiopathological aspects of the causation of coronary disease, Dr. P. R. Subbian followed with electro cardiac features and assessment of a case of acute heart attack. Dr. C. H. Sivaraman, Divisional Medical Officer, Southern Railways spoke eloquently on the aspects differential diagnosis of acute heart attack. Dr. N. S. Ramamurthy briefly dealt the subject of treatment and prognosis. After answering questions from the members Dr. Kalyanaraman summarised the topic and indicated the hazards in every day practice. Despite the failure of electricity twice, the audience was patient enough to listen to the speakers and the honorary secretary thanked the speakers and the moderator amply for their exemplary speeches. After extending a hearty vote of thanks to the president and members of the Palghat branch for their kindness in attending the symposium with a strength of 35 members, he accepted their invitation to the C. D. M. A. to attend the combined meeting at

Palghat in March 1963. He informed the house that the date for the proposed combined meeting at Valparai would be fixed after hearing from the Palghat branch about their final arrangements. He informed the members that dinner was awaiting them and the hosts for the day Drs. G. N. Rajagopalan, G. B. S. Mani, P. Punnaivanam and O. Kandaswamy were thanked by the honorary secretary. The dinner in buffet style commenced at 8-30 p. m. and there was a very cordial mix up by the members.

3. A combined meeting of the Palghat and Coimbatore branches of the Indian Medical Association was held at the spacious building of the Railway Institute, Olavakkot at 1 p. m. 3-3-1963. About 50 members from Coimbatore attended the meeting. The meeting commenced with a sumptuous lunch.

The president of the Palghat branch welcomed the gathering and the secretary of the Palghat branch read the minutes. Dr. C. V. Ramaraj, vice-president of the Coimbatore branch thanked the president and members of the Palghat branch for their invitation and hospitality. Dr. C. H. Sivaraman introduced the speakers of the day. Dr. P. A. Menon, F.R.C.S., Chief Medical Officer, Southern Railways spoke on 'Adhesions and Joint Stiffness' and Dr. K. P. Ganesan, M.D., of Kasthurba Medical College spoke on 'Medical Stock Taking'.

The meeting terminated with a vote of thanks by the secretary of the Palghat branch and later members had tea. On their way back, members of the Coimbatore branch visited Malampuzha and were entertained to tea by Dr. Sulaiman.

4. At the invitation of the Anamallais Medical Association, about 30 members of the Coimbatore District Medical Association left Coimbatore on 30-3-1963 by a special bus at 10 A. M. and reached Valparai at 1-30 P. M. The party was received by the president and members of the Anamallais branch at Mudis Staff Club and were entertained to lunch. Later with Dr. Jayachandran in the chair, a combined meeting of the two branches was held. Dr. T. Titus, District Medical Officer, Coimbatore, spoke on 'Acute Abdomen' and Dr. Mrs. K. Manonmani of Coimbatore spoke on 'Tuberculous Diseases in Children'. Dr. Mrs. Anna Vareed thanked the president and members of the Anamallais branch for their kind hospitality. Later the party was taken to Sholayar dam site and were entertained to tea at the guest house. The engineer, Sri Kuppaswamy, B.E., was kind enough to take the members round the dam site and explained to them in detail about the construction and the distribution scheme. The members departed from Valparai at 6 P. M.

5. A monthly meeting of the association was held on 7-4-1963 to mark the World Health Day, under the presidentship of Dr. Mrs. Anna Vareed.

Dr. G. T. Gopalakrishna Naidu, a member of our association was requested to speak on the theme of this year's World Health Day, 'Hunger — Disease of Millions'. The speaker gave an account of the campaigns undertaken by W. H. O. in the previous years and spoke at length on the significance of hunger, its effect on the populations' health, and measures needed to improve nutritional standards and the utilisation of food of high protein and calorific value.

Annual Meeting

The 38th Annual General Body meeting was held on 5-5-1963 in the association premises. After prayer at 2-30 P. M. the proceedings went under way with Dr. Mrs. Anna Vareed in the chair.

After the president's welcome address, the annual report and accounts were passed unanimously.

Then the president moved the resolution that hereafter our branch be called 'The Coimbatore Branch of I. M. A.' instead of 'Coimbatore District Medical Association, Branch of the I. M. A.' considering the fact that there are more than one branch of I. M. A. in our district. The motion was unanimously passed.

The following office-bearers were elected for the year :

President	: Dr. C. V. Ramaraj
Vice-President	: Dr. P. K. Kalyanaraman
Hony. Secretary	: Dr. N. S. Ramamurthy
Hony. Associate Secretary	: Dr. A. U. Natarajan
Hony. Treasurer	: Dr. K. R. Venkatesalu

Members to the managing committee and to the central and state councils of the I. M. A. were also elected. After the election of office bearers, the members were entertained to tea by kind courtesy of M/s. Rallis India Ltd.

At 4-15 p. m. the proceedings again commenced and at the request of the president Dr. Balagopala Raju, M. D., D. C. H., Professor of Paediatrics, Madras Medical College Madras gave a very interesting and illustrative lecture on 'Preventive Paediatrics'. He touched on the historical aspects of paediatrics and the growth of that branch through the ages and the present position of of paediatrics in our country. He stressed the importance of the preventive aspect and proper nutrition of children. He also emphasised the place and co-operation of the general practitioner in the 'Preventive Paediatrics'.

Then the president Dr. Mrs. Anna Vareed thanked the speaker and requested the president for the year Dr. C. V. Ramaraj to take up the chair and conduct the proceedings wishing him all success. Dr. C. V. Ramaraj accepting the chair thanked all the members for having elected him as president and assured them of his best services. He introduced the next speaker of the day Dr. Jayakumar, M. D., M. B., C. P., vice-Principal, Thanjavur Medical College and requested him to deliver his lecture.

Dr. Jayakumar talked on 'Steroid in Medicine'. The audience was held in rapt attention by his lucid and clear expression, punctuated by his wit and humour. He dealt with the pharmacology and therapeutics of the steroid group of drugs, their dangers and extreme usefulness in certain conditions as a life saving measure. After some discussion the president thanked the speaker. Then games (sports) were conducted in which many members took part. Owing to the inclement weather some of the outdoor games were cancelled.

At 8-30 p. m. the members were entertained to dinner by the kind courtesy of M/s. The South Indian Manufacturing Co., Madurai.

Mrs. Titus, wife of District Medical Officer, Coimbatore, gave away the prizes to the winners of the various items of sports. With a vote of thanks proposed by the honorary secretary the function came to a close.

Madura Branch:

1. A monthly meeting of the Indian Medical Association, Madurai branch was held on Saturday, the 20th April 1963. under the presidentship of N. Suryanarayanan, I. M. P., Madurai. Dr. D. Lakshmanan, M. S., Additional Reader in Surgery, Madurai Medical College and Surgeon, Earskine Hospital, Madurai gave an interesting lecture on 'Acute Abdominal Emergencies — Some Aspects'. The secretary Dr. D. R. Rajaram, M. B., B. S., proposed a vote of thanks.

2. A monthly meeting of the Indian Medical Association, Madurai Branch was held on Saturday, the 11th May 1963, under the presidentship of Dr. N. Suryanarayanan, L. M. P., Madurai. Dr. K. Jagannathan, M. D., D. T. M., Assistant Professor of Neurology, Madras Medical College and Neuro-Physician, Government General Hospital, Madras gave an interesting lecture on "Some Common Neurological Problems". The secretary proposed a vote of thanks and the meeting terminated.

Pudukottai Branch:

A combined meeting of the Pudukottai and Chettinad branches was held on 31st March 1963 in the premises of the Town General Hospital, Pudukottai. Dr. C. R. Thiruvengadam, M. B., B. S., the president of the Pudukottai branch presided. There was a lively symposium in which Dr. Mrs. Lalitha Kameswaran, M. B., B. S., Ph. D. (Lond.), Professor Pharmacology, Madurai Medical College, spoke on 'Treatment of Cough' Dr. S. Kameswaran, M. S., F. R. C. S., (Ed.), F. R. F. P. S. (G.), D. L. O., Asst. Professor of E. N. T. Diseases, Madurai Medical College spoke on 'Respiratory Diseases and E. N. T. Specialist' and Dr. T. Dorairaj, H. S., F. R. A. C. S., Asst. Paediatric Surgeon, Govt. Erskine Hospital, Madurai spoke on 'Surgical aspects of respiratory diseases in children'. Then followed an interesting discussion.

There was a film show by M/s. Sarabhai Chemicals on (a) Syphilitic Venereal Diseases (b) Raudixin (c) Malnutrition in Hospital patients. The meeting ended with a dinner and vote of thanks.

Ramanathapuram Branch:

An ordinary meeting of the Ramnad branch of I. M. A. was held on Sunday, the 19th May 1963 at 5 p. m. at the G. S. Hindu High School, Srivilliputtur. Dr. S. Raja Ayyar presided over the function. Dr. P. Krishna Menon, M. B., B. S., F. R. C. S. (Edin), Hon'y. Lecturer in Orthopedics, Madurai Medical College Madurai gave a very good lecture on 'Some Aspects of Fracture Treatment'. He also showed few slides and x-rays.

Salem Branch:

An ordinary meeting of the I. M. A. Salem branch was held on 26—5—1963 at 6 p. m. at the 'Hotel Dwaraka' Salem. Dr. Jayaramachandran presided. Dr. C. N. Santhanam, M. B., B. S., from Coimbatore addressed the members on 'Optimum Time for Paediatric Surgery'.

Tiruchy Branch:

1. A monthly meeting of the association was held on Saturday, the 30th March 1963 at the Medical Association Buildings, Tiruchy. Dr. C. Ramajachary, the president was in the chair. The president introduced the speaker

of the day Dr. G. Subramanyam, M.B., B.S., M.R.C.P., Additional Professor of Medicine, Madurai Medical College, and Physician, Govt. Erskine Hospital, Madurai to the members and requested him to give his talk on "Abnormal Cardiac Rhythms, their Diagnosis and Treatment". The lecturer gave an excellent talk on the subject and showed a number of slides on the subject.

2. A monthly meeting of the association was held on Saturday, the 20th April 1963 at the Medical Association premises, Tiruchy. Dr. C. Ramanujachary, the president was in the chair. The president introduced Dr. L. Sivaraman, M.B., F.R.C.S., Hony. Civil Surgeon, Thanjavur Medical College & Hospital, the lecturer of the day to the members and requested him to give his talk on "Thyrotoxicosis and Its Management". The lecturer gave an excellent talk on the subject and in the lengthy discussion that took place after the lecture, many members took part.

3. A monthly meeting of the association was held on Saturday, the 25th May 1963 at the Central Hospital, Golden Rock. About 50 members were present. Dr. C. Ramanujachary, the president was in the chair. After tea kindly given by Dr. G. Sakunthala and Mrs. Sampooranam Krishnan, the following condolence resolution was moved from the chair and passed unanimously all members standing in silence for 2 minutes.

"This meeting of the Trichy branch of I. M. A. records with great regret the sad and sudden demise of Dr. T. R. Rajagopalan an oldest member of the association. The secretary is requested to send a copy of this resolution to the members of his family".

Moved from the chair the following two resolutions were passed :—

"This meeting of the Trichy branch of I. M. A. congratulates Dr. S. Venkatesan a member of this branch on his election as joint secretary for the Madras State Branch of I. M. A. for the year 1962-63".

"This meeting of the Trichy branch of I. M. A. congratulates Dr. T. V. Srinivasan a life member of this branch on his election as senior alternative member of the working committee of the I. M. A. for the year 1962-63".

The president then introduced the lecturer of the day Dr. G. S. Ramachandran, B.A., M.B., B.S., D.L.O. (L), F.R.C.S. (E), Divisional Medical Officer, Southern Railway, Golden Rock to the members and requested him to give his talk on 'Deafness—Some aspects in the investigation and treatment of Deafness'. The lecturer gave an excellent talk on the subject which was very much appreciated by the members.

Madras State Branch:

A meeting of the Council of the Madras State Branch of the Indian Medical Association was held at the Medical School Building, Thanjavur, on Saturday, the 29th day of September 1962 at 2 P. M. 26 members were present. Dr. C. Nathamuni, the president, presided.

Calling the meeting to order, the president referred to his statement at the last meeting held at Srivilliputtur about his election as the official delegate of I. M. A. to the 130th Annual Meeting of the British Medical Association at Belfast. He informed the members that he left Madras on 18—7—1962 for Bombay enroute to Belfast, and that he attended the meeting and connected functions at Belfast, and represented the Indian Medical Association in all the said proceedings. He observed that the treatment accorded to the representative of the Indian Medical Association at Belfast was most cordial and that the delegates of several other countries to whom he was introduced had spoken highly of our I. M. A. and conveyed their best wishes and that the general atmosphere with reference to our I. M. A. was very congenial.

The council formally declared Dr. C. Nathamuni Naidu of Ambur as the president of the State branch for the year 1962—'63 and Dr. G. T. Gopalakrishna Naidu of Coimbatore as the senior vice-president and Dr. V. Samuel of Madras as the vice-president of the State branch for the year 1962—'63, who would assume charge of their offices from the 1st day of the 17th Madras State Medical Conference as per rules. These new officebearers were the recipients of congratulations from many members present in the house.

The honorary treasurer presented the statement of accounts for the months of July and August 1962 copies of which were already circulated to all the members along with the notice and agenda of this meeting. The council approved and recorded the statements.

The honorary treasurer then presented the statement of budget balance as on 1—9—1962 copies of which have been circulated already to the members with the notice and agenda of this meeting. The statement showed an excess expenditure of Rs. 267—42 nP. under the head 'Travelling allowance' over and above allotment of Rs. 1,000/- and the honorary secretary sought the permission of the council to ratify the same. Dr. G. Ramachandramurthy (of Madras) wanted to know the circumstances under which this excess had to be incurred. The honorary secretary explained that in this year the office of the state branch had been shifted to Madras city from Coimbatore, and that consequently more expenditure had to be incurred under the head "T. A." taking the factor of distance into consideration in contrast with the position when the office was all along at Coimbatore and the venue of the meetings of the council were nearer in location than now. Agreeing with the explanation of the honorary secretary, the council approved and ratified the excess expenditure, and observed that in the budget for the coming year the honorary secretary may take due care to provide a sufficient allotment under this head of expenditure.

The honorary secretary informed the House that the C. F. C. due for the year 1961—'62 has been received from all the branches except from the Madras city branch of I. M. A. in respect of which the C. F. C. for the 1st half year only was paid and the C. F. C. for the 2nd half has not been received upto the date of the meeting. He said that the branch was duly reminded, that the association year 1961—'62 will end by 30—9—1962, and that the non-payment of C. F. C. within the year will hamper the representation of the branch on the central council and is also likely to affect the representation of the state branch on the central working committee. He observed that unless all the branches pay up the C. F. C. dues in time, it would be difficult to carry on without unpleasant reactions. Dr. G. Ramachandramurthy observed that the C. F. C. problem with reference to the Madras city branch was a chronic one and that steps should be taken to solve it

amicably in order to conserve the privileges of the members in the I. M. A. The president appealed to Dr. R. Nanjunda Rao, one of the honorary secretaries of the Madras city branch, who was present in the meeting, to look into the matter and do the needful, and passed on to the next subject.

The Madras Clinical Journal:

- (a) Inclusion of the names of 2 representatives of the state council on the managing committee of the Journal:

The honorary secretary informed the house that he had addressed the honorary secretary of the Coimbatore branch to take steps to constitute a managing committee for the journal as per rule 2 (j) and to include the 2 representatives of the state council in that committee, to forward the personnel of this managing committee to the state branch and to publish the same in the journal. No reply has, so far, been received to this. There was a discussion on this question. Dr. T. M. Kumaraswami (of Vellore) wanted to know the functions of the editorial committee and the managing committee. The president observed that there was no provision in the rules for an editorial committee, that the rule requires a managing committee as defined in the rule, and that the branch should constitute such a committee. Dr. T. M. Kumaraswami then proposed that the branch should be asked to state categorically whether it will constitute a managing committee or not; and in the event of a negative replay, action should be taken to hand over the journal to another branch which would respect the rules. Dr. T. V. Sivanandam said that it would be better to wait for the reply of the branch before any drastic steps is decided upon. Dr. C. N. Santhanam said that the Coimbatore branch will not infringe the rules, that at best it may be considered as a lapse on the part of that branch in not replying to the state branch in time, and that a reply from the branch may be awaited. The president said that he was inclined to think that it was a clear case of violation of the rule by the branch concerned, and that he was placing the matter before the council for its verdict. In consideration of all the circumstances, the council felt that it was desirable to await the reply of the Coimbatore Branch to the letter of the honorary state secretary, and that the state secretary should intimate the branch about the sense of the council in this point and ask for a categorical reply; and adjourned the subject to the next meeting.

- (b) Publication of the audit report in the Journal:

The honorary secretary informed the house that as per the decision of the council at its last meeting, the journal office, I. M. A. Calcutta was consulted and a reply obtained that the audit report and statement of accounts of the J. I. M. A. are being published in the conference number or in a supplement there to if there is delay in obtaining the material. He said that the reply of the central Office on this question was not yet received. The council decided that if the editor of our journal feels that the audit report should not be published in the main issues on the grounds put forward by him in his letter, he may be asked to publish the audit report in the conference number of the journal or in a supplement thereto, which should be sent to all the members of the state branch. The honorary secretary was asked to communicate this decision to the branch concerned as well as to the editor of the journal.

- (c) Payment of pro rata share due to the state branch for the year 1961:

The honorary secretary informed the house that the pro rata share of excess income over expenditure for the year 1961 as per the audit report, due to the state branch which amounted to Rs. 1,997—00 has not been received so far,

although the branch was addressed to pay the same once on 22—6—1962 and again on 17—9—1962; nor has any reply been sent to our letters. The council asked the state secretary to again remind the branch and adjourned the subject to the next meeting.

(d) Statement of accounts for the quarter ending 30—6—1962 :

The honorary secretary placed before the council the statement of accounts for the quarter ending 30—6—1962 sent by the editor. It was seen from this statement that the managing editor has shown Rs. 1,200/- for the duplicator and Rs. 2,000/- for journals as liabilities. The honorary secretary told the council that he had informed the branch that as per the budget estimate sanctioned by the council there is no provision for the duplicator and that the provision for journals has been reduced to Rs. 600/- and that the next quarterly statement should take note of this. The council recorded the papers.

Communications from the Director of Medical Services, Madras :

(a) Prospectus of the short term Refresher Course in Venereal Diseases—October 1962 session :

The Council recorded this paper since copies of the same have been sent to all the local branches of I. M. A. in the state. The honorary secretary informed the house that now the D. M. S. has correctly mentioned all the 18 branches in the circular in contrast with the previous ones which contained faulty addresses.

(b) Amendment of the Madras Opium Smoking Rules 1955 consequent upon the introduction of metric system of weights :

The council recorded the communication containing an amendment to the Madras Opium Smoking Rules 1955. The amendment was made in consequence of the introduction of the metric system of weights, and the amendment provides for the substitution of "2 grams and nine hundred and twenty milligrams" for "a quarter of a tola" wherever they occur in the rules.

(c) Increase in the limit of possession of Morphine drug or preparations containing the drug by medical practitioners - clarification of the exact nature of practical difficulties which warrant the increase asked for :

The honorary secretary informed the house that the resolution passed by the council at its meeting held at Chingleput in April 1962 asking for an increase of the maximum limit of Morphine or preparations containing the drug from 30 gr. to 120 gr. as was obtaining prior to amendment of the rules, was communicated to the Drugs Controller and that the Drugs Controller had written to the state branch to state the exact nature of the difficulties of private practitioners which warranted this resolution. Since the resolution was sponsored by Dr. K. V. Swamy (of Madras) he was addressed to state the line of reply to be given to the Drugs Controller, but no written reply was received from him till the date of the meeting. The honorary secretary informed the council that he, however, had ascertained on the 'phone from Dr. Swamy that the increase asked for was necessary since a limit of 30 gr. may be alright for a practitioner in the city whereas practitioners in the mufassal may not be in as good a position as the city doctors to get their requirements whenever wanted, and that therefore an increase in the quantum would help them. A discussion ensued on this matter.

Dr. S. Venkatesan said that 30 gr. at a time was quite sufficient even for the mufassal practitioners. Dr. Maj. N. Chandrasekhar (Madras) agreed with Dr. Venkatesan in his views, and added that the Board of Revenue would permit higher purchases for individual doctors who may have the need for the same. Dr. C. N. Santhanam desired that the matter may be circulated to all the branches so as to elicit their views. Dr. T. V. Sivanandam said that at a time 30 gr. is quite sufficient and that the status quo may therefore be maintained and the council's prior resolution need not be pressed. The council taking the general sense of the house decided that the status quo be not disturbed and that the honorary secretary may inform the Drugs Controller that this association does not press its prior resolution.

The honorary secretary informed the house that some time back the state council decided on a reference from Dr. K. R. Venkatesulu of Coimbatore, to address government to amend the Madras Medical Attendance Rules so as to provide for granting medical concessions to the families of the honorary medical officers attached to government hospitals on a par with the government medical officers. The government were, accordingly, addressed. A reply was received from the Deputy Secretary to Government E. & P. H. Department that "the government see no justification for granting further medical concessions to honorary assistant medical officers; and for any treatment given to their families regular hospital stoppages are levied.

After discussion over the subject, the council decided that a deputation may wait on the Director of Medical Services and the Health Minister to explain our case and the deputation is to consist of (1) the president of the state branch (2) Dr. T. V. Sivanandam of Coimbatore (3) Dr. R. Nanjunda Rao of Madras (4) Dr. B. Rama Rau of Madras and (5) The honorary state secretary; and that the report may be placed before the council as soon as it is ready.

The honorary secretary informed the house that the central office has circularised all the local branches that for refresher courses that may be arranged by them financial assistance from the government of India will be available; and urged the branches to organise and conduct refresher course for general practitioners taking advantage of this scheme. The state branch has not, however, received so far any concrete proposals or news of the conduct of the refresher course for this year by any of its local branches. He further informed the council that in respect of a refresher course conducted by the Coimbatore branch of I. M. A. last year, a sum of Rs. 455—56 nP. has been allowed by the central office as the sum admissible for reimbursement, and the amount has been paid to that branch.

The honorary secretary further informed the house that there is a proposal to start an "I. M. A. College of General Practitioners" and that the central office had sent a "Draft Scheme" pertaining to the venture and called for the views of the state branch in the matter. The scheme is to be discussed by the central working committee and then finalised. The draft scheme is under scrutiny and consideration, and the views of the state branch will be communicated to the central office in due course and after clarification on certain points is received from the central office.

The council decided that in respect of the refresher course the proposals by local branches may be awaited, and that in respect of the proposed College of General Practitioners, the outcome of the Draft Scheme may be awaited.

Medico-legal cases in private clinics :

The honorary secretary recalled to the council the discussion on this subject at its last meeting held at Srivilliputtur. He told the house that he had addressed the Director of Medical Services, Madras on the question and that the D. M. S. has replied that "the medical officer should admit, all medico-legal cases only in government institutions and not treat such cases in his private clinic. If the case is a medico-legal one and is serious, as an emergency he is expected to treat the case in his private clinic but he should inform the police. The correct procedure is that whenever a serious medico-legal case is admitted in his clinic he should inform the police to make arrangements to get the magistrate to record the dying declaration. The action of the medical practitioner in asking the magistrate to go over to his private clinic to record the dying declaration is not in order". Proceeding, the honorary secretary told the house that he had communicated the views of the D. M. S. to the Salem branch of I. M. A. with a copy to Dr. M. A. Khan of Dharmapuri who raised the issue; that Dr. M. A. Khan had sent a long letter wherein he questioned in not very agreeable language the decision of the D. M. S. and insisted upon getting a considered opinion over the matter through the government or the medical council; and that the Salem branch of I. M. A. had also addressed the state branch to get a legal opinion over the decision of D. M. S. that private practitioners should not treat medico-legal cases, either from the Law Department of the Government of Madras or from the High Court, Madras. The honorary secretary had written again to the D. M. S. in the matter, and a reply was received from the D. M. S. that the matter is under examination and a further communication will be sent.

There was a discussion over the question. The president explained to the council that the D. M. S. was perfectly right in her letter. Dr. T. M. Pillay (Tiruvaiyyau) wanted to know the system obtaining in foreign countries over such problems. Dr. Maj. N. Chandrasekhar said that nobody could ask a magistrate to do a particular thing at that it is only the police who could requisition the services of a magistrate for dying declarations, that this is the usual procedure followed in government hospitals, and that the doctors will not call upon the magistrate to attend. Dr. V. Krishnamurthy (Cuddalore) said that we should not interfere with the present system in these matters. To an inquiry by Dr. A. Abdul Sattar (Madurai) whether private practitioners could not treat medico-legal cases, Dr. V. Krishnamurthy replied that by all means they could render medical aid and assistance, but that in serious cases necessitating the recording of dying declarations it was better to hand over such cases to the police. Dr. T. V. Sivanandam said that it was advisable for us not to interfere with the existing system and practice generally followed. Winding up the discussion the president observed that anyhow the matter has again been taken to the D. M. S. for reconsideration and clarification of her decision, and that we had better await the final outcome of it since it is likely that the D. M. S. will consult government before coming to a final decision. The council therefore adjourned the subject to the next meeting.

The honorary secretary informed the house that a letter dated 30-8-1962 was received from the honorary secretary of the Tirunelveli branch of I. M. A. as follows:-

"At a meeting of our association held at Tuticorin on 11-8-1962 it was decided by the general body to inform the state branch that our association does not desire to take part both in the nomination as well as election of president and vice-presidents for the year 1962-'63 in view of the fact that our branch has been neglected in the past in the matter of election of president".

The honorary secretary told the council that he had sent a reply to this letter on 6—9—1962 to the branch pointing out the incongruity of addressing such a letter to the state branch in view of the fact that the state branch, as such, should be, and is, above such accusations and that the business of the State Branch is conducted in strict accordance with the rules framed and regretting that such a letter should have been addressed at all. Dr. S. Rajaram Bharathi, a representative of the Tirunelveli branch of I. M. A. who was present in the meeting said that he was not present at the meeting held in Tuticorin and observed that he would have objected to such a decision had he been present. The council expressed its regret that such a letter should have come from one of the oldest of our local branches.

With the permission of the president, the following resolutions were duly passed:—

- (i) "This meeting of the council of the Madras state branch of I. M. A. resolves to request the Government of Madras to give representation to the medical profession through this association in the Madras Legislative Council".
- (ii) "This council while thanking the Chief Minister of the Government of Madras for his assurance to give to the house surgeons their stipends without any discrimination request the Government to pay such stipends to all the house surgeons with retrospective effect, namely from the beginning of the financial year".
- (iii) "This council of the Madras state branch of I. M. A. views with grave concern the increasing number of cases of food poisoning in Madras state and impresses upon the Government the need to set up a strong and influential committee for a thorough investigation of the causes and prevention of such cases, and to include the president of the Madras state branch of I. M. A. in the committee to be so formed".
- (iv) "In view of the increased prosecution of manufacturing firms in respect of sub-standard drugs discovered, this council of the Madras state branch of I. M. A. request the Union and State Governments to inform the Indian Medical Association the names of the concerned firms and cause publicity in medical journals so as to ensure an effective check against the use of such products".
- (v) "In view of the fact that medical men with the GCIM qualification are extensively employed in Government and other services, this council feels that medical men with this qualification should be made eligible to become members of the I. M. A. and in this view this council urges the central I. M. A. to so amend its rules as to provide for the admission of GCIMs. as members of the I. M. A."

The following resolution moved by Dr. Ramachandramurthy was passed:—

"This council notes with deep concern the way in which the Dean of the Stanley Medical College and Principal of the Madurai Medical College have called for applications only from Registered Medical Practitioners who had put in a practice of not less than 20 years for the recent Refresher Course held for General Practitioners from 12—9—1962 to 25—9—1962 in the above-said colleges, and requests the Government to remove the limitation of the practice for the future courses to be conducted, since the medical science is making rapid strides year after year in the methods of diagnosis and treatment".

Annual Report for the Year 1961-'62

Presented at the Annual Meeting of the Council of the Madras State Branch of the Indian Medical Association held at the Annamalai University Campus, Annamalainagar, Chidambaram, on Saturday, the 27th April 1963 :—

During the year under report the membership strength of the state branch of I. M. A. has registered a decrease by 39. It is of great importance that our strength should be increased as much as possible so as to make our association strong and unified; and the co-operation of all the office-bearers at the state and local levels is earnestly solicited to achieve this aim.

The C. F. C. due from all branches except for the Madras city branch for the second half year has been received. A total sum of Rs. 13,781—50 nP. has been realised during the year and the quota of the central office has been remitted. I would, however, appeal to all the branches to make it a point to send their list of deletions in time and to remit the C. F. C. dues also in time and thus obviate several difficulties for the state branch in this regard.

The following meetings were held during the year :—

1. At Vellore (Annual Meeting: 22—12—1961)
2. At Chingleput (Ordinary Meeting: 28—4—1962)
3. At Srivilliputtur (Ordinary Meeting: 14—7—1962)
4. At Thanjavur (Ordinary Meeting: 29—9—1962)

The following is the comparative statement of attendance of members of the council at the meetings of the state council during 1960—'61 and 1961—'62 :

1960—'61		1961—'62	
<i>Total strength: 92</i>		<i>Total strength: 100</i>	
Place of meeting	Number of members attended	Place of meeting	Number of members attended
1. Ootacamund	26	1. Vellore	36
2. Madurai	35	2. Chingleput	21
3. Tiruvithamcode	16	3. Srivilliputtur	13
		4. Thanjavur	26

I cannot but observe that the attendance at the meetings of the state council is only about 30% on the average, and this is a very low figure considering the strength of the council. The meetings of the council are held, on purpose, at different places in the state so that the members resident in and around that centre shall have opportunity to attend and take part. It is necessary that each branch is represented by at least one representative who can voice the opinion of that branch. Since the decisions of the council represent the view of the I. M. A. in the state it is necessary that members of the council make it preferable to attend in person or at least send their views in writing on any subject on the agenda which they would like to convey so that they may be considered at the meeting before taking a decision.

The Coimbatore branch of I. M. A. continues to run the journal of the state branch, the Madras Clinical Journal, with Dr. A. G. Leelakrishnan as the Editor.

During the year under report, Dr. C. Nathamuni Naidu was the president and Drs. T. V. Srinivasan and V. Samuel held the office of the two vice-presidents. For the year 1962—'63, Dr. C. Nathamuni Naidu has been re-elected as the president and Dr. G. T. Gopalakrishna Naidu and Dr. V. Samuel have been elected as the two vice-presidents. The offices of the honorary secretary and Treasurer were held by Dr. A. Pattabi and Dr. B. Rama Rau, respectively; and Dr. T. M. Kumaraswami of Vellore adorned the office of the honorary joint secretary.

The office of the state branch which was, for the past 5 years, at Coimbatore, has been shifted back to Madras, and the office is located at the residence of the honorary secretary, free of rent. The work of the state branch is being carried on with one full-time clerk-typist. The accounts of the state branch are maintained in due and proper form and got audited by chartered accountants appointed by the state council. However, due to the shifting of the office to Madras and other contributory factors expenses on some heads have risen up, resulting in excess expenditure which could not be avoided. The audited statements of accounts are circulated to members separately. The fixed deposits of the state branch, amounting to Rs. 11,000/- have been invested for a period of three years in the George Town Co-operative Bank Ltd. at 6% interest per annum.

The main source of income to the state branch is only the quota to it allowed by the central I. M. A. on C. F. C. collections, and with the amount thus realised in view of the decreasing strength it is found difficult to balance the budget due to increase of charges all round. I would like to place this administrative difficulty before the council for a solution and for ways and means to augment the main source of income.

STATE PRESIDENT'S LETTERS

1. Sub: National Emergency - Defence Efforts.

Anent my previous appeal to you on the subject, I am approaching you all, once again, by this letter of appeal for your valuable help and co-operation in strengthening our defence efforts.

Apart from the liberal monetary contributions to the National Defence Fund by individual doctors, the active participation by the doctors in respect of the following matters will be of great significance for the defence of our country :

(a) **Voluntary Service:** Private medical practitioners cannot only aid the defence efforts by volunteering to render medical aid at stated hours in the hospitals or other places in their own towns, but they can also render a very significant service by enlisting the services of non-medical persons - male & female - to do several auxilliary jobs, ranging from Secretarial work to Nursing and rendering First Aid. Able bodied men, as well as women, can join this service and serve the country for a couple of hours a day when the need arises. They will be given special training for the duty expected of them, and they may apply for enrollment to the Director of Medical Services through the Indian Medical Association or the Medical Officer of their place.

(b) **First Aid:** A First Aid Manual is being printed by Government. All private practitioners can coach the people in their localities to render First Aid to the injured. Such trainees will be registered in their respective Centres and can serve when called upon.

(c) **Facilities for Training of Private Practitioners:** Facilities are now available for Orientation Training, Training in Traumatic Surgery and Anæsthesia for private medical practitioners. All private medical practitioners may avail themselves of this opportunity to get themselves trained and serve the cause of the country. The District Medical Officers in their areas will help them further in this behalf.

(d) **Technical Services:** Members of the I. M. A. who own X-Ray Plants and other similar equipments are requested to serve the country by throwing open their Establishments for the needs during emergency and rendering their expert services. Members who are prepared to serve in this capacity may intimate the Director of Medical Services through the I. M. A. or the District Medical Officers.

(e) **Active Service:** Unlike the previous wars when different Nations were at war with each other, the War we are now faced with concerns directly our dear motherland. All medical men who are aged 40 and below are requested to join the Army Medical Corps where even a raw medical graduate is assured of a start of Rs. 600/- per month. I shall be undertaking a State-wide tour in this connection ; and I hope to have your whole-hearted help and co-operation.

*

*

*

*

2. It is my desire to reach every member of the I. M. A. of your branch through you by means of this letter. I take this opportunity to convey to you all my sincere and heart-felt thanks and gratitude for having elected me as your

president for the year 1962-'63; and I beg to assure you all that I shall spare no pains on my part to do my duty by the association with its best interests at heart. I thank you most sincerely for all your kind co-operation and support extended to me during the past year and helping me with your able advice and guidance to transact the business of this state branch of I. M. A. at the various meetings of the state council held so far; and I am confident that I shall be having your willing co-operation and backing in the deliberations of the state council during the current year also.

The present strength of our state branch which is round about 1700 bears a very low ratio to the total number of medical men belonging to the allopathic system in our state which is about 5600. Your kind help is most essential considering the scattered number of medical men throughout the state, to increase our strength at least two-fold; and I trust that I shall be having the same in a large measure. We are in a state of National Emergency; and it is our duty to stand by our government in all their efforts of National Defence; and here again, I appeal to you for your kind co-operation in doing our duty by generously contributing to the Defence Fund and by coming forward to render voluntary services whenever and wherever needed.

As a member of the Medical Committee of the Citizens' Council I shall be touring the state shortly in connection with defence efforts; and I shall be banking upon your full and hearty co-operation in the success of my tour.

The 17th Madras State Medical Conference recently held at Annamalaiagar (Chidambaram) on the 27th and 28th April 1963 over which I had the honour to preside as a representative of you all, was a very successful one; and matters important to the medical men in service as well as in private practice were deliberated and decided in the form of resolutions. The success of the conference was possible entirely due to your unstinted co-operation; and I hope and trust that I shall be having such whole-hearted co-operation from you all in the future too. I, for my part, wish to assure you all of my humble services for the cause of our association and the medical profession which I shall be glad to render to the best of my capacity.

Thanking you once again, and with kind regards.

Yours sincerely,

C. NATHAMUNI NAIDU,

President.

MADRAS STATE BRANCH—AMENDMENT TO RULE 20.

The attention all the members of I. M. A. Madras State Branch is invited to this office Circular No. 5/62-63 dated 14—3—1963 on the subject which was circulated to them through the Hony. Secretaries of their respective branches. The proposed amendment to Rule 20 of the Rules of the Madras State Branch of I. M. A. was circulated in that circular and objections or suggestions were called for to be sent before 5—4—1963.

The subject was considered by the State Council of the Madras State Branch of I. M. A. at its annual meeting held on 27—4—1963 at Annamalainagar. The only suggestion received from Dr. G. J. Narayanaswami Naidu of (Madras) to the effect that it would be enough if the alternate member produces his own letter instead of a letter of authorisation from the President of the concerned branch, was considered unacceptable by the Council, and the suggestion was therefore rejected.

In exercise of powers vested in it as per Rule 26 (g) the State Council of the Madras State Branch of I. M. A. has directed the amendment of Rule 20 as notified in Circular No. 5/62-63 dated 14—3—1963 to come into force with immediate effect and that the amendment shall be published in the Journal of the Madras State Branch of I. M. A. for the information of all the members of I. M. A. in the State.

The amended Rule 20 is, therefore, hereby notified to all members of the I. M. A. through their respective local branches and the Editor of the Madras Clinical Journal, Coimbatore is requested to publish the same in the next issue of the Journal.

Rule 20: (as amended)

"20. (a) The name of the representatives shall be communicated by the local branches concerned to the Hony. Secretary of the State Branch immediately after the election. Members so elected and the ex-officio member of the State Council shall continue to be members of State Council until their successors are elected.

(b) In case of any of the elected representatives of the local branch are unable to attend a meeting of the State Council, the President of the local branch may nominate any other member or members (as the need may be) of the local branch to deputise for them for the particular meeting of the State Council. The Deputies so attending shall produce their credentials (nomination letter signed by their President) before signing their names in the Minutes Book of the State Council".

*

*

*

*

MADRAS MEDICAL COUNCIL — DISCIPLINARY CASES.

Removal of certain names from Madras Medical Register:

1. On information received from the Joint Secretary, Board of Revenue (Commercial Taxes), Madras, that Dr. T. G. Sundaram, L. M. P. (Mad.) (1923), 6-A, Mowbrays Road, Royapettah, Madras-14, had, in January 1960, issued about thirty-two prescriptions for pethidine hydrochloride in the names of

fictitious patients with fictitious addresses, that in some cases the doctor himself had taken delivery of pethidine hydrochloride from the chemists on the strength of these prescriptions, that he had evidently obtained the drug for misusing the same and that he has thus misused the privileges conferred on registered medical practitioners in the prescribing of dangerous drugs, the Madras Medical Council held an inquiry into the matter on the 18th March 1963 and found him guilty of infamous conduct in a professional respect. In exercise of the powers conferred on it by section 16 (2) of the Madras Medical Registration Act, 1914 (IV of 1914), the Madras Medical Council by resolution, dated the 18th March 1963 directed the name of Dr. Sundaram, Tharuvai Gopalakrishna Iyer, L. M. P. (Mad.) (1936) son of Gopalakrishna Iyer and holder of registration certificate No. 8932, dated the 3rd March 1923, be erased for a period of two years at the end of which period he may apply for re-registration. Along with his application for re-registration he should produce certificates of good character from two registered medical practitioners of the Madras City.

2. On information received by the Madras Medical Council that an institution under the name and style of Thilaga Medical Institute was functioning at Madurai and imparting instruction in western medicine with Sri N. Tangaraj as Director and that two registered medical practitioners Dr. J. A. Royappa, L. M. P. (Mad.) 1928, Medical Officer, C. C. Hospital, Madurai and Dr. D. Athisayam, L. M. P. (Mad.) 1923, No. 1, Rajendra Street, Karimedu, Madurai-10, associated with the said Director of the Institute, Sri N. Tankaraj, an unqualified person, in the running of the said institution for the imparting of Western Medical science by taking up appointments as Instructors and imparting instruction in the said science to the students of the said institute and conducting examinations and also affixing signatures in the certificates issued by the said Institute on completion of the course and that the said Institute was not one recognised under the Indian Medical Degrees Act, 1916, the Madras Medical Council held an inquiry against the said Medical Practitioners on 18th March 1963 and found them guilty of infamous conduct in a professional respect. In exercise of the powers conferred on it by section 16 (2) of the Madras Medical Registration Act, 1914 (IV of 1914), the Madras Medical Council by resolution, dated 18th March 1963, directed the names of Dr. Royappa John Antony, L. M. P. (Mad.), 1928, son of M. Royappa Pillai and holder of registration certificate No. 4573, dated 19th November 1929 and Dr. Athisayam Naicker, David, L. M. P. (Mad.) 1923, son of D. Naicker and holder of registration certificate No. 3529, dated 16th January 1926 be erased for a period of one year at the end of which period they may apply for re-registration with testimonials of two registered medical practitioners of the district where they are practising.

Madras, }
18th March 1963. }

G. KRISHNAMURTHI,
Registrar, Madras Medical Council.